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THE HEALTH CARE CRISIS AND THE AMERICAN FAMILY

HEARING

BEFORE THE

COMMITTEE ON LABOR AND HUMAN RESOURCES UNITED STATES SENATE

ONE HUNDRED SECOND CONGRESS

FIRST SESSION

ON

EXAMINING PROBLEMS OF THE NATION'S HEALTH CARE SYSTEM AND RECOMMENDATIONS FOR REFORM, FOCUSING ON THE NEED FOR UNIVERSAL ACCESS TO HEALTH INSURANCE AND LONG-TERM CARE FOR THE ELDERLY

JANUARY 10, 1991

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THE HEALTH CARE CRISIS AND THE AMERICAN FAMILY

THURSDAY, JANUARY 10, 1991

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The committee met, pursuant to notice, at 9:05 a.m., in room SD-430, Dirksen Senate Office Building, Senator Edward M. Kennedy (chairman of the committee) presiding.

Present: Senators Kennedy, Pell, Simon, Adams, Wellstone, and Durenberger.

OPENING STATEMENT OF SENATOR KENNEDY

The CHAIRMAN. The committee will come to order.

As the record will show, these are extremely important and challenging times for the leadership of both the Senate of the United States as well as the House of Representatives.

We had invited the Majority Leader Senator Mitchell, who had every intention of joining with us since he has made the whole issue of health care a top priority as a member of the Finance Committee and also as our Majority Leader. He has a statement which we will include in the record—Chris Williams, his chief health advisor, has joined us at this hearing, and we very much appreciate her presence—but we will include Senator Mitchell's statement after the opening statements of the members of the committee.

Momentarily we expect Congressman Gephardt, who has had a long and continuing interest in health care policy. This has been one of the very important areas of public policy that he has spent a good deal of time on and is remarkably well-informed about and has testified on a number of occasions before our committee in terms of the details of the policy.

Congressman Gephardt and I have worked together in the past on these issues, and I will say a brief word when he arrives.

Today is a continuation of our committee hearings to try and look over the basic domestic agenda. These are overview hearings, and we are very hopeful that the remainder of our legislative priorities will take into consideration the really superb testimony that we had during the earlier hearings dealing with the impact on the average family of this recession and the fact that we have enormous focus and attention, as we should, in terms of the 400,000 American troops that are in the Gulf. But as I mentioned at the opening of the hearings, we do not think it is appropriate that the

parents of those who are in the Gulf are writing to their (AK) loved ones from unemployment lines across this country. And as we are prepared to spend the billions of dollars which may very well be necessary hope will not be necessary—in an armed conflict, or even the billions of dollars which are necessary to maintain our current military posture in the Gulf, to restore the Emil of Kuwait, we have to think about the adverse financial impact on millions of American families who are either out of work increasingly in an economy that does not respond to their talents or their needs, and who are stretching their families not only from an economic point of view but from a human point of view of very significant dimensions.

One of the areas of expenditure that is just devastating to average working families, let alone those who are not working and do not have any kind of coverage, and those who are working and don't have any coverage, as well as those who are working, have some coverage but don't have adequate coverage, is the explosion of health care costs and the inadequacy of our response.

I am very hopeful that this will be the health insurance Congress. It is a top priority of mine and has been for 23 or 24 years, and as I have said it has been an issue which I have taught round and taught flat. I am not very much interested in what is on the next 386 pages as long as we have a comprehensive program that will eventually be universal and of high quality, at a Price that the average family can afford to pay.

[The prepared statement of Senator Kennedy follows:]

PREPARED STATEMENT OF SENATOR KENNEDY

Today is the third in the series of hearings by the committee on the domestic challenges the Nation faces. The subject this morning is health care.

More and more, access to affordable health care is as serious a problem for middle class families as for low-income citizens.

We start with the almost unbelievable fact that in this rich land of 250 million Americans, 37 million of our fellow citizens, including 24 million working men and women and their dependents, have no health insurance at all.

An additional 26 million Americans will have no insurance for substantial periods of time this year, often as long as 6 or 7 months. And there are 60 million more Americans who have insurance, but whose insurance is so poor that even the Reagan administration said it was inadequate.

Those who are adequately insured today are only one missed heart-beat away from losing their coverage—one management cost-cutting decision away—one pink unemployment slip away in this recession—from joining the ranks of the uninsured. Virtually all Americans are at risk—but it is low-and middle-income families who are most at risk.

Every year millions of citizens are turned down for needed health care or do not even seek it because they cannot afford it. Four out of every 10 hospital admissions in Washington, DC could be avoided if patients had obtained timely medical care when their

symptoms first began, Four out of 10 American children do not even get basic childhood immunizations against disease.

Americans are also paying more and more for the health care they are able to obtain—and getting less and less value for the dollar. We spend more on Health care than any other country—40 percent more per person than Canada, 90 percent more than Germany, and twice as much as Japan.

In the 1980's the average annual increase in the consumer Price index was 4.7 percent—but the increase for health care was 10.4 percent, more than twice as high. Since annual earnings by workers increased only 4 percent a year, a larger and larger slice of the family budget is going for health care every year.

We spend $700 a day for a hospital bed, when more appropriate care could be provided in a nursing home for $70 a day.

We dump people into nursing homes for $25,000 a year, when we could enable them to live in their own homes for $5,000 a year.

In sum, we have a competitive health care system today, in which the best of health care and the worst of health care are competing side by sideband the worst is winning. I regard that as a national disgrace.

The system is bankrupt, and its consequences are literally bankrupting many American families, and plaguing every other family. If an FDIC could take over our failing health care system tomorrow, 250 million Americans would say, "Amen."

Today's hearing focuses on this crisis and the need for action. Now is the time and this is the Congress to deal with the two great needs of Americans health care—insurance for all Americans, and long-term care for the elderly and disabled. Few issues are more important or more urgent for working families across the Nation. I intend to do all I can to see that congress meets its responsibility.

For a very brief comment, I recognize Senator Simon and very briefly Senator Wellstone, because the Leader has to be out of here in about 20 minutes.

Opening Statement of Senator Simon

Senator Simon. Just very briefly, one area we could move on quickly—and I recognize that comprehensive care is not going to be in the immediate future, although I favor it—but long-term care, we ought to be able to move on. And it is interesting that in the last election I suggested a half-percent increase in Social Security taxes to fund it on a pay-as-you-go basis, and I ran into very little opposition to that. I think the American people are ready for it.

Then let me tell you about two people. I had a town meeting in Rolling Meadows, IL, a Chicago suburb that Congressman Gephardt may be familiar with. A woman got up and said, "I had cancer. As far as I know I am rid of it. My insurance has gone up to $1,400 a month, and the insurance company has reserved the right to cancel it or raise it on 30 days' notice. And I can't get insurance anyplace else."

How many families can afford $1,400 a month health insurance?

Then, in a little town outside of Peoria, we had a meeting, and health care came up, and afterward a man named Jack Liven Good came up to me and said, "I had a lung problem. My physician told

me I had to have a lung transplant or I would die. I checked, and my insurance didn't cover it, and they said it would cost $120,000." And he said, "That was just beyond anything we could dream of. What I did was to move to Canada long enough to establish eligibility, and I got the lung transplant. As you can see, I am in good health. They send me my medicine once a month. I pay $9 a month for it; would cost me $200 a month here."

Something is wrong when an American citizen in order to save his life has to move to Canada. We can do better.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Senator Wellstone.

OPENING STATEMENT OF SENATOR WELLSTONE

Senator WELLSTONE. I'll be very brief.

Thank you, Congressman Gephardt, for being here today. It is good to see you.

Mr. Chairman, I am here for almost very personal reasons. Such a somber time—we are now about to have the debate on the Gulf—but this is the war I really want to fight, the war against men and women in our country not being able to afford health care, not having access to dignified and humane health care. That is why I am here today.

The CHAIRMAN. Thank you very much, Senator Wellstone.

[The prepared statement of Senator Mitchell follows:]

PREPARED STATEMENT OF SENATOR MITCHELL

I appreciate this opportunity to join with Chairman Kennedy and Majority Leader Gephardt to voice my concern about the existing health care system in this country and to express my commitment to improve that system.

Access to affordable, quality health care should be a right for all Americans. As we know, all Americans do not have access to such care.

The American health care system is the best in the world. For most of this century, many of us accepted that statement as a simple reflection of fact.

Those who disagree with this statement point immediately to the Canadian system of health coverage, or one of the Western European systems. They ask, if our system is so great, why don't we rank first in the world in infant mortality rates, or some other measure of well being?

The answer is well know.

We have the best health care technology in the world, but we have not yet worked out how to make it reach every one of our citizens.

That is the challenge today, as it has been throughout our history. Today the shape of that challenge has been changed by two factors: cost and demographics.

Thirty-seven million Americans today have no health insurance coverage of any kind, generally because they can't afford the premiums. Two-thirds of them are working people and their dependents—people whose jobs do not provide what was once considered a routine benefit, health insurance.

One-third of those without health insurance coverage are children. Children are more prone to accidents, more vulnerable to illnesses and to environmental stress. If we ignore the health care of our children now, it will cost us more to deal with the effects later.

Clearly, the Nation needs the support and commitment of both the Congress and the Administration if we are to reduce our shameful infant mortality rate—which is now higher than in 19 other nations including Singapore and East Germany.

While our children face an uncertain future—the Nation is, at the same time, faced with the most dramatic demographic change in our history.

At the turn of the century, one in 25 Americans was over the age of 65. Today one in eight Americans has reached that age. The fastest growing group in our Nation in percentage terms is the over-age 85 group.

Fortunately, medical advances have enabled us to live longer and ADLpt to greater levels of disability during our lifetime. But it is also a well-documented fact that the largest portion of health care is consumed during the closing years of life. So the implications for the American health care system are clear: A greater demand than ever before for acute and chronic care.

The twin challenges of a substantial uninsured population and a growing elderly population confront a health care system that is not prepared to meet the challenge of providing access to care for all who need services.

Hospitals and other public health facilities have been providing treatment to the indigent on an ad hoc basis, necessarily shifting costs to those who can and do pay.

It is not enough that we find a way to add those who are uninsured to the existing health care system. We must make fundamental reform in that system, including effective cost containment efforts and insurance market reform.

I believe it is critical that the States and the Federal Government work together to find a way to provide affordable care for all of our citizens.

Health policy in the United States for the past decade has been driven primarily by cost considerations. Whether we look at the efforts of the Reagan administration to cut such programs as child immunization, or at more recent efforts to control medical cost inflation overall, the driving force has been costs.

Bust cost cutting alone does not constitute health policy. We as a nation need to make explicit decisions about what we want to pay for. If, as a society we want to assure access to basic health care services for all of our citizens, we must decide how much we are willing to spend and where those dollars will come from.

We must decide if we are willing to provide a meaningful long-term care benefit for elderly and disabled Americans—and if so what will be the limitations on those benefits and how will the burden be shared between government and private mayors?

Consumers too, must play a part. We all like to hear the latest medical news—the newest drug—the most recent medical breakthrough to improve our lives. But consumer demand is part of the cost problem too. We must moderate our demand on the health care system and at the same time take more individual responsibility for a healthy life style.

On a societal level, we must decide whether an investment in preventive health care now will save money in the future. I believe that we must invest in prenatal care and childhood immunizations. We must commit ourselves to clean air and water. These are examples of investments in the health and betterment of our Nation. But choices like these mean placing a value on competing interests for public expenditures.

In addition to making difficult tradeoffs, we must assure that each dollar spent gives us its best return. I believe that we can get more value for the over $500 billion we spend each year on health care. Last year both Senator Kennedy and I sponsored legislation to fund research into the effectiveness of medical treatments. It is estimated that between 10 to 30 percent of treatment for illnesses provided by physicians is either unnecessary or ineffective.

I hope that the new Agency for Health Care Policy and Research, established through effectiveness legislation will improve the quality of care while reducing unnecessary costs.

Many of the States have been innovators in health care reform. Congress should look to the States to determine whether some of those innovative programs might be appropriately expanded on a national level.

But, at the same time, the Federal Government cannot, and should not, expect the States alone to be responsible for health care reform. Congress and the Administration must provide leadership in insurance reform, cost containment strategies and expanded coverage for the poor and elderly for both the public and private sectors of the health care system.

Developing and financing such reform will be difficult. Our recent experience with the Catastrophic legislation has illustrated just how difficult it will be to develop and finance expanded health care benefits.

We must also work with the Health Insurance industry to encourage improvements in access to insurance for all working Americans, regardless of health status or occupation. It is encouraging to see that the insurance industry is responding to the crisis in access to health care with its own proposals. That is a good start.

And, in spite of our experience with the Catastrophic legislation, we must continue to work toward a viable long-term care policy which will provide care to the elderly based on their health care needs, rather than which services are reimbursable.

The elderly whose families cannot care for them privately have spent themselves into poverty and now consume, for long-term care needs, almost half of the Nation's

total Medicaid budget—ironically, the very program that was intended to help extend care to the poor.

I do not suggest that the provision of long-term care coverage, in and of itself, will solve all of the problems of the uninsured. But clearly, Medicaid—the program that was established to help the least advantaged in our country—is disproportionately spending its resources on long-term care for the elderly. Thus one unmet need has, inadvertently but inexorably, helped worsen another.

The interaction of these problems, of working persons and children without coverage and elderly persons without coverage for the most costly form of care, illustrates the kind of dilemma that a society faces when there is no long-range public policy.

The Congress must begin to focus on comprehensive reform of the health care system. Each year the Congress is faced with recommendations for deep cuts in the Medicare program and a growing demand for Medicaid coverage for the poor. We must look beyond the immediate crisis of budget cuts in health care programs toward restructuring our health care system in a way which will provide services to all who need them while controlling the rapidly escalating costs of health care.

We must give time and thought to the long-term policy goals that we want to see for American health. We should pay attention to the population that will be paying for health care in 30 or 40 years' time. If we do not, we risk seeing our health policies lurch from emergency to crisis, decade after decade, while the best health care system in the world fails to reach every one of the people for whose benefit it was developed. That's a result we must work together to avoid.

These will be difficult challenges in the light of the overwhelming budget deficit. However, we must continue to look for solutions failure to do so could result in the ultimate collapse of this Nation's health care system.

The solution to these problems are among my highest priorities this year.

The CHAIRMAN. As I mentioned earlier, Congressman Gephardt, we had the good opportunity to cosponsor legislation in 1984, 1985, and we have benefited from your testimony in the past and are delighted to have you here this morning. We know you are under a time bind, but we appreciate your being here. You are certainly one of the most thoughtful leaders on this whole health care issue. We know it is a high priority of yours and hopefully the Congress'.

We look forward to what you have to say.

STATEMENT OF HON. RICHARD A. GEPHARDT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MISSOURI

Mr. GEPHARDT. Thank you very much, Senator Kennedy.

I appreciate very much the opportunity to be before this distinguished committee. I do recall with you the time we worked on health care legislation in 1984 and 1985 and continue to believe that if we had been able to pass that legislation the health care system would be working better today than it is. I enjoyed very much that opportunity and look forward to working with you in the days ahead as we fashion a new health care policy for America.

Senator Simon, it is always good to be with you. I welcome the opportunity to have this discussion today.

Senator Wellstone, it is a great honor to be here with you today, and I agree with you that the war that we need to be fighting is this one because it is on the minds, as Senator Simon said, of all of our constituents. Every meeting that I go to, health care is the number one question that gets asked with great concern by my constituents.

I want to commend your committee for its leadership on this issue. I think this is an issue that is easily put aside even though it commands the interest of our constituents because it is such a complicated and difficult issue to deal with.

But no one saw the crisis that we have in health care coming sooner than you did, Senator Kennedy, nor has anyone worked harder to address it. I know that you and your colleagues on the committee will continue to work with us in the House in the development of a long-needed health care policy for America.

I think as we move into the 1990s, we are faced with a troubling paradox. We have the best health care in the world for some. I was interested in your story, Senator Simon. I have heard other stories where Canadians who can't get something they want, and they have the money to afford it, come to the United States. I guess we have the odd circumstance where some in one country can't get something, and they are coming here; and we've got a lot of citizens who have no health care at all and so, like your constituent, they have to go somewhere else. It seems to me we ought to be able to figure out how to make it work for all Americans.

So it is a good health care system for some, but as we know, providers are increasingly struggling to deliver it; too few people have access to it, and those who do are increasingly anxious about its cost.

I think you know the problems. There are 37 million people who have no health care insurance at all; almost as many who are underinsured. I talk to constituents almost every week who think they have health insurance, and it turns out that it doesn't cover the problems they happen to have. Health care costs continue to outface inflation, and I don't need to give you the facts on that, but ever since I have been in the Congress, now 14 years, we have noticed that health care inflation has been higher than the rate of normal inflation. It has come down a little bit, but the truth is it is still outfacing inflation by at least double, and in some years it was up three and four times the rate of inflation, which obviously leads you to understand that something extraordinary is happening.

Health insurance premiums are soaring, and malpractice premiums are skyrocketing. Hospitals are closing. Many in my district have closed and are in the process of closing. And doctors and nurses are leaving the practice of medicine.

There is unhappiness almost anywhere you look in the system. And we have an aging population with ever-growing health care needs, rapid and expensive technological changes. And we have a shrinking and unreliable Federal contribution to health care.

We must now acknowledge that these problems are exacting an unacceptable toll on our people and on our economy. Older Americans live in constant fear of the crippling costs of a chronic illness or a nursing home stay. Working Americans worry about the impact on their family budgets of increases in health care insurance premiums that they cannot control, and (AK) mothers living in poverty agonize over their inability to get help for their sick children.

Doctors, nurses and other health care professionals and paraprofessionals struggle with frustration over the magnitude of human need and suffering that they are unable to assuage.

We can be grateful that with all of the problems and frustrations, we still have thousands of caring individuals who deliver truly wonderful care.

Sometimes we too easily understand all the problems in the system, and we fail to recognize that there are thousands of individuals, doctors, nurses, paraprofessionals who work in the field, many of whom work at low wages, and do a very wonderful job for our people; really care about the health care of our people.

Back in 1972 my son was critically ill and considered to be terminal at the time, in a children's hospital in St. Louis. He was brought through that difficult period and is alive today primarily because of the caring attitude of individual nurses and doctors in that institution. I doubt that they could ever have been paid for what they did for us. I know that experience has been felt by millions of Americans.

So as we criticize and talk about the problems in the system, we have got to remember the heroic job that is being dl day-by-day by thousands of people who work in the system. But I think their jobs are harder than they should be. And business leaders who pay a heavy Price, both direct and indirect, for increases in health care costs are at a disadvantage with their competitors in other countries whose costs are lower.

I am concerned that our economy is suffering from a drain of corporate resources pouring into health care coverage and from the loss of productivity that results when people cannot afford to seek medical care when they need it.

We have kind of assumed, I think, in this country that because 37 million people or 40 million people don't have health care, don't have health care coverage, that somehow we are saving money. I know no one wants to do that, but the assumption has been that we can't afford to cover these people; we can't afford it—as if they are not getting sick today, as if they are not showing up in emergency rooms and getting inefficient care, and that care is not being paid for by putting it on the premiums of people who have insurance.

It has amazed me when people have said you can't afford to cover the 37 million Americans. Can't afford—we are doing it now. We are just doing it inefficiently. We are doing it by adding the costs to the health care premiums of the people who have insurance. So it is not a sensible system.

I am equally concerned about the human costs, the drain on our people's health and peace of mind. Let me tell you about a letter that I received from one of my constituents in Fetus, MO. She wrote me about her parents. Her father had lost his job of 25 years. His COBRA-mandated coverage was about to expire, she said, and the only coverage her parents had been able to find would cost them $1,000 a month.

She said, "My dad is 56, and he can't find another job. How are they going to afford those premiums? Either way, my parents are going to lose everything they have worked for in 37 years of marriage. That is not fair."

We agree; it is not fair. Nor is it necessary. We can do better, as Senator Simon said, and it is time to start. The American people want action, and they believe that health care reform is an area in which the Federal Government bears primary responsibility; I believe that.

The House leadership agrees, and I know you agree, Mr. chairman, and I believe the members of the committee who are here agree.

During the Reagan years, Congress engaged in an annual battle with an administration determined to curtail drastically the Federal contribution to the availability of health care to our people. We succeeded in reducing the cuts, and in some instances were able to achieve some modest expansions in access to care, especially for pregnant women and children. But as the Reagan era drew to a close, we all know that a real national health care crisis was upon us.

Unfortunately President Bush, despite his inaugural plea for a "kinder and gentler Nation", has followed his predecessor's budget priorities and allowed his administration to remain suspended for 2 years in a State of inaction and apparent indifference to the health care crisis that threatens our people. The Bush Administration seems to have missed the simple truth that my constituent from Fetus saw when she said, "We are entitled to life, liberty and the pursuit of happiness"—her words in her letter. "But how can we achieve those when much of our hard-earned money goes for medical insurance or we face death because we cannot afford needed treatment?"

Mr. Chairman, it is time for Congress to take the lead in enacting health care reform. The reforms must be major and I think national in scope. Their goal must be to ensure access to quality, affordable health care for all Americans.

I believe that in addition to basic health care for all, we must begin to address the needs of older Americans for long-term care, particularly home- and community-based care.

I was at a meeting of seniors in my district at holiday time. I talked with each group, and they all talked about the home-based care that is given by some of the senior centers in my district. But about half of them don't have it. So the only alternative in many cases is to go to the nursing home, which is the most costly way of dealing with the problem.

We must also do a better job of ensuring that we spend our dollars well. Providers should be encouraged and enabled to provide care in the most efficient and effective manner possible. A better understanding of medical treatments and their outcomes would enable providers and consumers to make better choices. And I hope that the Federal Government will play a larger role in gathering and disseminating this information.

There are many policy decisions, both large and small, that remain to be made before we can pass health care reform of a scope that our people await. But let us understand that we can make the commitment to universal access to necessary health care now, before we make choices about the changes we need to make and the kind of system or systems we want to put in place to achieve the goal.

I personally think it would be best to build on what we have, rather than starting anew with an entirely changed and different system. It would be noted, for example, that the efforts of Congress over the past eight or 10 years in the area of cost containment I think have begun to show some results. Let us not throw that

progress aside. Clearly, more can be done, but Ergs have slowed the growth of hospital costs to Medicare—they may be shifting it now to the private sector, but it has cut the costs to Medicare—and our recent physician payment reforms were carefully devised and promise to do the same for physician costs.

I think we have got to use this experience, not throw it away, in both the public and private sectors, as we develop a new national strategy to ensure access to health care for all Americans.

There are of course those who would disagree and want to throw the whole system out and start anew. I welcome a debate on their views and on the options that are before us.

The important point now is that it is time for Congress to make a commitment to ensuring universal access to necessary and appropriate health care. It will not be easy to convince our colleagues to pass it. It will not be simple to get a consensus in the country behind it. But I think it is the necessary next step to solving our health care problems.

I think the United States House of Representatives is ready to make that commitment; I hope that it is. The House Democratic Leadership has begun meeting with Representatives Stark and Waxman and others who exercise a leadership role in the House on health care issues. Within the next few weeks, the Speaker will announce that health care legislation will be our highest priority of our agenda for the 102nd Congress. And I expect that we will begin work in earnest on major health care legislation in the first weeks of this Congress.

I think that promoting and preserving the health of our citizens is the most important goal that we can achieve as a Nation. Someone stated the obvious that without your health you have nothing. I think most Americans understand that and put this issue in that place of priority.

I welcome the opportunity to work with you in the days ahead as we work together to put in place an improved health care for the American people.

Thank you very much.

[The prepared statement of Mr. Gephardt follows:]

Prepared Statement of Representative Gephardt

Chairman Kennedy, I want to thank you for the opportunity to speak with you and your colleagues this morning at your Committee's important hearing on the health care crisis and the American family. I also want to take a moment to salute you for your leadership in this area and for your unflagging determination to alleviate the burdens of the millions of Americans who are in the grip of the health care crisis. No one saw this crisis coming sooner than you did, nor has anyone worked harder to address it. I know that you and your able colleagues on this Committee will continue to play an important role in the development of much-needed health care policy in the Congress.

Mr. Chairman, as America moves into the 199's, we are faced with a troubling paradox: we have the best health care in the world—but providers are increasingly struggling to deliver it, too few people have access to it, and those who do are increasingly anxious about its cost.

The problems are by now well recognized: 37 million people with no health care insurance; almost as many who are underinsured; health care costs that continue to outface inflation; health insurance premiums soaring and malpractice premiums skyrocketing; hospitals closing and doctors and nurses leaving practice; an aging population with ever-growing health care needs; rapid—and expensive—technological advances; a shrinking and unreliable Federal contribution to health care.

We must now acknowledge that these problems are exacting an unacceptable toll on our people and our economy. Older Americans live in constant fear of the crippling costs of a nursing home stay or chronic illness. Working Americans worry about the impact on their family budgets of increases in health insurance premiums that they cannot control. (AK) mothers living in poverty agonize over their inability to get help for their sick children.

Doctors, nurses, and other health care professionals and paraprofessionals struggle with frustration over the magnitude of human need and suffering that they are unable to assuage. We can be grateful that, with all of the problems and frustrations, we still have thousands of caring individuals who deliver truly wonderful care. But their jobs are harder than they should be.

And business leaders who pay a heavy Price, both directly and indirectly, for increases in health care and insurance costs, are at a disadvantage with their competitors in other countries whose costs are lower.

I am concerned that our economy is suffering from the drain of corporate resources pouring into health care coverage and from the loss of productivity that results "when people cannot afford to seek medical care when they need it. But I am equally concerned about the human costs: the drain on our people's health and peace of mind. I think of the letter, one of many with the same message, that I received recently from one of my constituents in Fetus, MO. She wrote to me about her parents, about her father who lost his job of 25 years. His COBRA-mandated coverage is about to expire and the only coverage her parents have been able to find would cost them $1,000 per month. My constituent wrote, "My dad is 56 and cannot find another job. How can they afford those premiums? Either way, my parents are going to lose everything they have worked for in 37 years of marriage. That is not fair."

I agree: it is not fair. Nor is it necessary. We can do better than this—and it is time for us to start. The American people want action, and they believe that health care reform is an area in which the Federal Government bears primary responsibility. The House Leadership agrees, as I know you do, Mr. Chairman.

During the Reagan years, Congress engaged in an annual battle with an administration determined to curtail drastically the Federal contribution to the availability of health care for our people. We succeeded in reducing the cuts, and in some instances were able to achieve some modest expansions in access to health care, especially for pregnant women and children. But as the Reagan era drew to a close, we all knew that a real national health care crisis was upon us.

Unfortunately, President Bush, despite his inaugural plea for a "kinder and gentler Nation," has followed his predecessor's budget priorities, and allowed his administration to remain suspended for two years in a state of inaction, and apparent indifference to the health care crisis that is threatening our people. The Bush administration seems to have missed the simple truth that my constituent from Fetus saw when she said: "We are entitled to life, liberty, and the pursuit of happiness. But how can we achieve those when much of our hard-earned money goes for medical insurance or we face death because we cannot afford needed treatment?"

Mr. Chairman, it is time for Congress to take the lead in enacting health care reform. The reforms must be major, and national in scope. Their goal must be to ensure access to quality, affordable health care for all Americans. I believe that, in addition to basic health care for all, we must begin to address the needs of older Americans for long-term care, particularly home- and community-based care.

We must also do a better job of ensuring that we spend our health care dollars well. Providers should be encouraged, and enabled, to provide care in the most efficient and effective way possible. A better understanding of medical treatments and their outcomes would enable providers and consumers to make better choices, and I hope that the Federal government will play a larger role in gathering and disseminating this information.

There are many policy decisions, both large and small, that remain to be made before we can pass health care reform legislation of a scope the people await. But let us understand that we can make the commitment to universal access to necessary health care now, before we make choices about the changes we need to make and the kind of system or systems we want to put into place to achieve this goal.

I personally believe that it would be best to build on what we have, rather than starting anew with an entirely different system. It should be noted, for example, that the efforts of Congress over the past 8 or 10 years in the area of cost containment have begun to show some results. Clearly more needs to be done, but Ergs have slowed the growth of hospital costs to Medicare, and our recent physician payment reforms were carefully devised and promise to do the same for physician costs.

I think we should use the experience and the successes we have gained over the years, in both the public and private sectors, as we develop a new national strategy to ensure access to health care for all Americans. There are, of course, those who would disagree, and I welcome a full debate of all our health care policy options. The important point is that it is time for Congress to make a commitment to ensuring universal access to necessary and appropriate health care.

The U.S. House of Representatives will make that commitment. The House Democratic Leadership has been meeting with Representatives Stark, Waxman, and others who exercise a leadership role on health care issues in the House. Within the next few weeks the Speaker will announce that health care legislation will be the highest priority on our agenda for the 102nd Congress. I expect that we will begin work in earnest on major health care legislation in the early months of the first session.

Promoting and preserving the health and well being of all our citizens is one of the most important goals that we as a nation can achieve. Mr. Chairman, I commend you and your colleagues for your Committee's commitment to this goal, and I look forward to working with you toward the day when no American, regardless of age or employment status, will go without the best health care in the world.

The CHAIRMAN. Thank you very much, Congressman Gephardt, for your testimony and your continuing concern and leadership in this issue.

The fact that the House Leadership is putting this as its highest priority is I think certainly important news for all Americans, and it is welcome news.

I just previously included in the record the statement of Senator Mitchell, who had hoped to be here. In his last line he says, "the solution of these problems is among the highest priorities this year." So hopefully this will be the health insurance Congress.

I know you have to go. Let me just ask two questions. In whatever we do, I gather that you believe that some type of cost containment is an important feature of anything we do in terms of opening up accessibility and availability of health care. Do I understand that correctly? Too frequently, those of us who are proponents of expanding health care coverage get asked about this issue, and I have heard you speak eloquently about it, and I think it is important that you underline it.

Mr. GEPHARDT. We simply cannot launch any new access measures without continuing and increasing our cost containment capability. I think we have learned a good deal from what we have done, but I think we have to do more.

As you know, our legislation in the mid-Eighties tried to take the prospective payment idea and other ideas that were out there and apply it to the private sector as well, State-by-State, allowing States to use different methods. That may be something we need to look back at and pull into the present. But cost containment has to be part of any measure, that is absolutely correct.

The CHAIRMAN. You mentioned in your testimony that the Federal leadership is a central part of this whole effort. Let me ask you a somewhat philosophical question.

Given the general state of the American people's feelings about the Federal Government and governmental institutions, and having gone through this whole decade which has been sort of the "me decade", or however you want to describe it, the decade of greed and personal enhancement, do you think there exists the kind of intuitive capabilities for us to develop something that does involve a lot of caring, a lot of sharing, a lot of trust, and belief in

institutions? Do you think we, as a society, can move into that type of a framework that can result in something that is going to work?

Mr. GEPHARDT. People are not against government or government doing things. What they are against is ineffective government. What they are against are ineffective, inefficient, wrongheaded programs that don't produce the result. People want health care. They like Medicare, I think. It is a huge government program that has been around for a long time. I think it works. It is not perfect, but it sure is respected by the American people.

I think if you went to the American people today and asked would you like to take Medicare away, get rid of government, let private individuals take care of it, you would have a resounding "No".

So I think what people have reacted to is waste and inefficiency and where government has gone awry. I think what they want is effective service, and that is our job, that is our responsibility, and I think we can do that.

I also believe that in health care we have had a good partnership between the private and the public sector. Medicare has been a partnership. We have tried to use the strengths of the private sector to make that a good program, and I think we have done pretty well at it.

The CHAIRMAN. Will you agree with me that after we pass this bill most people will ask why did it take us so long to get it?

Mr. GEPHARDT. That's what they said in 1965 when Medicare got passed.

The CHAIRMAN. Senator Simon.

Senator SIMON. I simply want to commend Congressman Gephardt for his leadership, not just today, but continually in this field. The points you make are absolutely valid. You talked about hospitals. Illinois in the last 10 years has had 32 hospitals close, most of them in areas of great need, because that is where you have the Medicare and Medicaid patients. And we are shifting the burden, because we are not paying adequately for hospital care, over to the private carriers and ultimately to the people sitting in this audience and elsewhere.

I do think that when we work this out, and we add the overages necessary, we are going to have to do it on a pay-as-you-go basis. But I believe the American people are ready for that. They recognize we have some massive deficiencies. The problem is not with research—although we ought to be doing more in several areas of research—but the fundamental problem is health delivery, and we are not doing what we ought to be doing. Out of 20 developed nations, industrial nations, we are 18th in our infant mortality rates. That is a shame. We ought to be doing better than that.

So I simply want to commend you. And particularly now that you are Majority Leader over there, I hope we can see the House and the Senate move and come up with something that really is solid.

Thank you.

Mr. GEPHARDT. I thank you very much for your continued leadership.

The CHAIRMAN. Senator Wellstone.

Senator WELLSTONE. Mr. Chairman, Congressman Gephardt, I have so many questions and there is so little time that I will wait for now—questions across-the-board.

I have only one very brief comment. Mr. Chairman, you asked the question about the government and how people respond to government programs. I believe, and I am more convinced about this now than I was 2 years ago when I first started campaigning, that people do believe that in certain decisive areas of social life the government can and should play a positive role in improving people's lives. I think health care is such an area, and I think whether or not we adopt some kind of a national health care program that will respond to people is going to be a test case of whether or not we have a system of democracy for the many here in Washington, DC, since the many really are calling for the change, or a system of democracy for the few. And I believe we have a system of democracy for the many.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much.

Thank you, Congressman Gephardt. If I could intrude on your time, would you meet our witnesses?

Mr. GEPHARDT. Surely.

The CHAIRMAN. We have Sue Tiller and her son, Nathan; Sharon Burton; Edith Parekh from Massachusetts; and Steve Tilghman and his son, Chris.

Mr. GEPHARDT. I want the record to note that this man has very wonderful red hair.

The CHAIRMAN. Maybe he'll grow up to be President. [Laughter.]

Mr. GEPHARDT. Thank you, Mr. Chairman.

The CHAIRMAN. I'd like to welcome our second panel of witnesses. They are people who have experienced first-hand the problems plaguing our health care system. In this sense, we truly have a panel of experts sitting before us.

The first witness is Steve Tilghman and his son Chris, from Birmingham, AL. Mr. Tilghman will speak about the difficulties of obtaining health care for his son who has epilepsy.

Chris, I understand you are a champion speller and are giving up the chance to defend your championship today. We are very appreciative of your presence.

Our second witness is Sharon Burton, from Abingdon, MD. Mrs. Burton will discuss the regiving responsibilities in her family, especially about the tremendous need today for long-term care services.

Our third witness, Edith Parekh, is a nurse from Chelmsford, MA. She is well-versed in caring for Alzheimer's patients both as a professional provider and as a care giver to her ailing mother.

I understand that the weather up north has been particularly hazardous, and you took that long train down from Boston; I am sure you are still shaking from those tracks. In any case, we are thankful for your presence here today. We know you have come a long way, and you have very important testimony for all of us.

Mr. Tilghman, we'll start with you.

STATEMENTS OF STEVE TILGHMAN, BIRMINGHAM, AL; SHARON BURTON, ABINGDON, MD, AND EDITH PAREKH, CHELMSFORD, MA

Mr. TILGHMAN. Thank you, Mr. Chairman, members of the committee.

On behalf of the Epilepsy Foundation of America, I appreciate the opportunity to appear before you this morning to explain the problems which my family has experienced in securing health insurance during the past 2 years. Our problems are not unique. Millions of Americans have a difficult time getting health care protection. Many work for business which do not provide or offer health insurance. Others are unemployed. Still others, like myself, are self-employed. The problem is compounded when a family member has a medical disability or disorder. Our family is one such family as Chris, who is here with me today, has epilepsy.

Five years ago I was a partner in with a Big Six accounting firm. Health insurance was no problem. We had good, adequate coverage. For the first 18 months after making a career change, I was able to retain that same insurance coverage under the provisions of COBRA.

Approximately 2 years ago our health insurance coverage began. COBRA coverage expired. The administrator of my former firm's health plan offered to continue similar coverage but wanted $1,000 per month 450 percent insurance at that time. There was no way that our family could afford to pay such a premium.

After 2 months, our insurance agent found health insurance coverage for four members of our family with an A-plus-rated insurance company. However, the company refused to cover Chris. I asked them to consider taking him on with a pre-existing condition exclusion. They refused. They would not provide any coverage under any circumstance.

Our insurance agent was able to find a separate individual health policy for him from an unrated insurance company. While my agent prefers to deal only with companies rated A or better, this was the only policy she could find. The policy is a two-year nonrenewable policy that excludes his pre-existing condition, epilepsy. Thus we have no real insurance on the member of our family having the greatest known need for health care.

My insurance agent warned me that any claim which might be submitted would potentially be challenged. The insurance company would probably try to claim that the need for medical attention was a result of his epilepsy.

I asked her what would happen if, for example, he had a bicycle wreck. Her guess was that the company would contend that the seizure was the cause of the accident. There was no way that we could disprove their contention.

In effect, our family is self-insured. When visiting Chris' neurologist I always answer the clinic's question about insurance coverage by telling them I am the insurance company. I try to make light of the situation, but it is no laughing matter. Medical tests are not cheap. While all of Chris' doctors are sensitive to our situation and try not to overdo the testing, there is still a level of care which

must be rendered. I, like other parents, do not want to compromise my child's health for financial reasons.

I mentioned earlier that Chris has health insurance coverage under a two-year nonrenewable policy. Well, the 2 years expires on March 31, 1991—less than 3 months from now.

My wife is more and more frequently asking the question, "What are we going to do about insurance coverage on April 1st?" I don't know the answer. The lack of an answer creates real fear and anxiety for her. That is not to imply that I have any less concern.

The health insurance coverage that the other members of our family has continues to increase every 6 months. This time last year, my premium was $223. This month I am paying $340, a 52 percent increase over last year. And this is for coverage that only covers part of our family.

I have also learned that this same insurance company has stopped writing coverage for single family units. That means I cannot even get similar coverage today if I wanted it from them.

As a self-employed CPA/consultant with a wife who has three part-time jobs, one of which is also a self-employment situation, we are unable to obtain adequate health insurance coverage. We are luckier than many families in that we do have some coverage on every member of our family—today. Come April 1, Chris may not have any coverage for his medical or health needs.

Gentlemen, this is scary. I don't like the feeling. there is real stress in living with the uncertainty of what access to adequate health care families like ours should have and expect.

Our family, like millions of others, looks to you and your colleagues to find a solution in this session of Congress so that all Americans can have adequate, affordable health care.

Thank you.

The CHAIRMAN. Before going to the other witness, I want to tell you, Chris, that we are very glad to have you here. Could I ask you just a brief question?

Mr. CHRIS TILGHMAN. Yes, sir.

The CHAIRMAN. Chris, as I understand it you are a champion speller; is that right?

Mr. CHRIS TILGHMAN. Yes, sir.

The CHAIRMAN. And you are missing the playoffs today to be here with us.

Mr. CHRIS TILGHMAN. Correct.

The CHAIRMAN. Did you speak to your teacher about coming up here?

Mr. CHRIS TILGHMAN. Yes, I did. It was imperative that she knew about it.

The CHAIRMAN. Yes, that's a good idea. [Laughter.] What did she say?

Mr. CHRIS TILGHMAN. She really didn't have a whole lot to say. As a child she was afflicted with polio, so she is very sensitive to health coverage needs, and so she was just happy that I could come up here.

The CHAIRMAN. It just goes to show again that there is really not a family that is not affected by these health challenges.

I understand you have not had a seizure in some 2 years; is that correct?

Mr. CHRIS TILGHMAN. That's correct, sir.

The CHAIRMAN. And you like to ride a bicycle; is that right?

Mr. CHRIS TILGHMAN. That's a big hobby. I love it.

The CHAIRMAN. How far do you ride, usually?

Mr. CHRIS TILGHMAN. Oh, it is different. Some days, I can't even get outside; some days, it will be up to 30 miles. Every day is really different.

The CHAIRMAN. And you are a swimmer, too?

Mr. CHRIS TILGHMAN. Yes, sir. That is my main sports commitment. That takes up two and a half hours in the afternoon, and sometimes, if I go to practice in the morning, that is 4 hours a day.

The CHAIRMAN. What do you swim?

Mr. CHRIS TILGHMAN. The free style is probably my best long-term thing. Right now, breast stroke is where I am excelling.

The CHAIRMAN. You would like to continue to do that and finish school.

Mr. CHRIS TILGHMAN. Yes, sir.

The CHAIRMAN. Do you plan to go on to college?

Mr. CHRIS TILGHMAN. Yes, sir.

The CHAIRMAN. Do you do pretty well, academically?

Mr. CHRIS TILGHMAN. Yes, sir; I'm doing real well.

The CHAIRMAN. I'll bet you are. [Laughter.] If there is any question about what the responsibilities are to try and ensure coverage for Chris, I think it is pretty well understood.

Thank you very much.

The CHAIRMAN. Mrs. Burton.

Mrs. BURTON. Thank you very much.

Good morning, Mr. Chairman and members of the committee. Thank you for the chance to talk about my family regiving responsibilities, which include my 4 year-old daughter, Sarah, my 86 year-old grandmother who has Alzheimer's, and my 54 year-old mentally retarded aunt.

On June 22, 1990, Mary Cottrell, my grandmother, was taken to Falls Ton Hospital because of a fall. After testing and exams, Granny was diagnosed with dementia Alzheimer's. Before her fall, Granny had been taking care of her daughter, who is 54 years old and mentally retarded since birth. While Granny was still in the hospital, we kept her daughter, Aunt Jane, at home with us. A neighbor came in and stayed with Aunt Jane.

After 5 days, Granny was ready to come home. This is when our problems began. Who would take care of both Granny and Aunt Jane now that they could no longer live by themselves?

The three grandchildren—my sister Sandy, my brother David, and I—held a meeting to determine what had to change in order for Granny and Aunt Jane to have the proper care. David is the legal guardian for Granny, so finances fell on his shoulders. Over the years, Sandy had been overseeing health needs. It was decided that this was to stay Sandy's responsibility.

Before Granny's fall, I was living a quiet, normal life with my husband Frank and my 4 year-old daughter Sarah. When I was able, I would help out in any way I could. We needed to make fast decisions. We had the following four options: to provide 24-hour private home care, which was financially out of the question; to place Aunt Jane in a nursing home—a nursing home would not accept

Aunt Jane with Granny; to move the two in with other family members, which was never an option; to have someone outside of the family live with Granny.

Caring for an Alzheimer's patient alone is an all-day job and very hard work. In addition, we still had Aunt Jane, who is highly dependent on us.

On July 5, 1990, I moved into Granny's home and took over care for her and my aunt. It was a big change for my daughter, because she had previously had her mother all to herself. Now Mommy had Granny, Aunt Jane, Daddy and her to care for.

David arranged through the American Legion for a hospital bed and a wheelchair. I made the house "Granny-proof" so she could not hurt herself. For example, I removed the stove knobs, put all Sharp things out of reach.

Granny gained three pounds in the first 6 weeks that I had moved in, and I am extremely proud of that.

In doing medical checks, we found Granny was diagnosed years ago with pernicious anemia, which is incurable at her age. This enabled us to get limited home health care and home nursing.

In terms of our budget and finances, Granny and Aunt Jane get Social Security. Aunt Jane gets a small amount from Veterans' Administration. We work out the rest of the finances as best we can.

In summary, a lot of lives have changed. Granny does not even realize anymore who she is or where she is. She is with us in body, spirit and love. Her mind is gone, but she can still make you laugh and cry.

Aunt Jane has been enrolled into a Saturday special school. A whole new life has opened for her. She too has made many adjustments. Small children are in the house now because on a trial basis move, my older daughter Sharon, husband Alan, and 3 year-old son Brand live upstairs. The move has worked out well because Sharon has been a godsend in her help and experience in working with Alzheimer's patients. Sarah and Brand love Granny, but when she goes for their hair, she moves away; when she wants hugs and kisses, they are there waiting.

At this point, everyday care is routine, and problems are minor.

My life has changed the most. I cannot just pick up my three-member family and go somewhere. I need a sitter for Granny and Aunt Jane. I have no quiet moments because someone always needs something. Granny takes a lot of time, work and attention. We cannot get out of the house and do things like other family members. For example, we cannot eat dinner out because finances do not allow us to hire a sitter for adults.

We know that Granny's condition will someday become worse. We are worried about that and what that will mean to our future. Taking care of two small children, a daughter, a son-in-law, a husband, Aunt Jane and Granny has certainly turned my 24-hour day into a 36-hour day. And because of Mary Cattrell's need for care, I will make sure my grandmother does not go to a nursing home where I can no longer see my grandmother smile, her laughter, her tears, and the love she has for "the girl" who takes care of her.

Thank you.

The CHAIRMAN. Thank you very much, Sharon.

Edith Parekh.

Mrs. PAREKH. Good morning, Mr. Chairman and committee.

My name is Edith Parekh, and I come from Chelmsford, MA. I am a nurse with a degree in human services and management. At first, I was prepared to talk to you from my prepared notes, but after hearing what I have heard this morning I have decided not to talk from my prepared notes.

One of the disenchanting facts about being a nurse is that if one of your family members happens to become ill, you have an inside track on exactly what is going on. In my case, this happened about 10 years ago. My parents came for a visit. It was our eldest child's graduation from high school. I noticed that my mother was acting in a very different way.

We were all in bed one Sunday morning when I got a telephone call from a local motel that a woman was there and had said to call this number. To my shock, when I scrambled out of bed and got in my car and drove over to the motel, it was my mother. She had walked about seven miles from our house and was totally lost, but within herself, she didn't see anything wrong with it—appeared to her that I was lost, and what took me so long to get there.

I spoke with my dad about it, and he couldn't see anything wrong. He said, oh, she was just going for a walk and was probably tired.

After graduation, they went back home, which was 600 miles from where I live in Chelmsford. Then the problems began to emerge little by little. One day I called Mom. "How are you?"

She said to me: "You have stolen a tablecloth, and I want it back."

I was in shock. I became angry. I couldn't get her to change her mind. That was it.

Well, to make a long story short, as a nurse I began to see evidence of Alzheimer's disease, and knew that something would have to be done for mother. My parents have been married 50 years, and I am the only child. And quickly, when I assessed what was going on, I decided that what I would have to do would be to take full responsibility for my mom, because my dad certainly couldn't do it.

So I brought her home to live with my husband and four children. And although it seems that to bring an Alzheimer's person into your home is a major complication, it has some advantages on how you look at life and how you assess the needs of others. That is the reason why I weathered one very bad, icy storm, and a very long trip on a train last night, to come here and tell you that there are things that can be done.

I work in a small facility called Community Family in Lowell, MA. It is funded by the Robert Wood (CT) Foundation. We have been in business for about a year, and this year, after Brandies University assessed us, we have been given three more years of funding.

It is a very small but new facility. We have about 24 clients who come on a part-time or full-time basis 6 days a week. I am the memory disorder specialist, and I work specifically with a small group of people—not regaining their memory, of course, because with Alzheimer's, once you lose your memory it is lost forever—but

by making their time meaningful, creating activities, and trying to bring them back into society in a small but safe way.

After listening to the many things that I have heard this morning, I came up with some ideas of my own that I wish to share with you. It is definitely needed long-term care—but how does one incorporate that into a community of other people and other needs?

One thing I have learned within my own personal family is that the sharing with children and elderly people brings about a very warm and quality type of relationship. Our lives have certainly changed because Grandma now lives with us, and with all of the things that have to be changed in the house such as safety, doorknobs changed, knobs on stoves taken off, alarm systems installed, the police department being notified that in your home there is an Alzheimer's person in case they should wander away, identification that they wear and a card that they carry in the event that they do get lost so people know that this is not a deranged person, but this is a person who truly has lost her memory.

It might interest you to know that Alzheimer's can happen to anyone from middle age on up. And what is scary is that there are more than two million people in the United States with Alzheimer's disease. Some Alzheimer's patients even outlive their caregivers—and then what? Who will take care of them?

My thought on the matter is that within communities across the United States, we could establish long-term facilities, perhaps in conjunction with day care because there is a wonderful relationship between the elderly and children. Here, we could address many, things that need to be done. We can monitor good nutrition because just because you have Alzheimer's does not mean that your nutritional needs cannot be kept up. Children need day care services, and by combining the two, we need the needs of a very large population.

One thing that I'd like to share with you is that if we don't put into effect research—because this is a disease where there is no cure—if we don't spend money for research we may never find a cure.

Second, if we do not educate our generation, they will continue to grow with a lack of sensitivity and generosity. Senator Kennedy mentioned that we come from an age of me-is, and that has to change. The world is so much smaller—and the same with our own lives. So education, funding for research and long-term planning so that in the long run we are not left with a whole population of people whom no one will care for.

When you leave this building today, you are going to leave with two things, for sure. You are going to know who you are and where you are going. And if by chance when you walk out on Washington's streets this afternoon, you meet someone you know, consider that an advantage of being a well and healthy human being. Which one of these things are you willing to give up? That is what happens with Alzheimer's—you lose it all.

Thank you.

The CHAIRMAN. We thank all the witnesses for the very I think moving way of portraying the health care crisis in a fashion that I think every family can relate to and presenting the challenge to us

here to play our role in trying to address this real crisis, this everyday crisis that is affecting so many American families.

Let me start with you, if I could, Mr. Tilghman. What are the kinds of bills you look at in terms of the out-of-pocket expenses that you face in terms of medicine and tests?

Mr. TILGHMAN. Generally, we have to pay, obviously, the health insurance premium for Chris, but then in addition since it is an exclusion related to his epilepsy we pay all drug bills, we pay his visits to his neurologist for period checkups, so to speak, as relates to his epilepsy; we pay for blood level tests to make sure he has the right level of medication in his system. This summer we probably this summer will have to pay for an KEG, a CAT scan, and an SRI, as they assess where he stands since he has not had a seizure for the last 2 years as to where they go forward with that level of treatment. That will be at least a $1,000-plus day for me, or 2 days.

The CHAIRMAN. And none of that is covered even by the current insurance program.

Mr. TILGHMAN. No, sir; that is my expense.

The CHAIRMAN. And that is beyond your own family premiums; is that correct?

Mr. TILGHMAN. Correct.

The CHAIRMAN. And you consider those to be the minimum level of tests, but at least a kind of preventive measure

Mr. TILGHMAN. That's correct. In essence it is more health care hospitalization type coverage that we have, and even then, particularly in Chris' case, it is a question of whether coverage even exists.

The CHAIRMAN. You had a successful career with one of the principal important accounting firms, and then you went into your own practice. Do you find that, just because of concerns for your son and the health care needs of yourself that you might have to make a career change and return to a large firm?

Mr. TILGHMAN. That is a real concern my wife and I have had, that one of us is probably going to have to make some career decision again in the next few months, regardless of what we might like about that particular career just to be able to hopefully have some level of health care protection for our family.

The CHAIRMAN. And I suppose there is some concern for the fact that you might even be able to do it, given the kinds of economic problems that we are facing.

Mr. TILGHMAN. It is not easy out there, particularly right now, where even white-collar people are now facing some of the layoffs and recessionary problems that in the past have been more a blue-collar problem.

The CHAIRMAN. Your wife works in three jobs?

Mr. TILGHMAN. She is a school teacher at the same school where Chris attends; she is a church organist and music director, and also a piano teacher.

The CHAIRMAN. Let me ask you how you feel as a businessman. We hear a good deal about mandating coverage, putting the burden on business as well as the Federal Government.

Mr. TILGHMAN. Well, that's a mixed type situation. I think a lot of small businessmen want to be able to provide coverage a lot of times to their employees. Richard Nugent with the Epilepsy Foun-

dation was sharing with me last night about a restaurant owner in Houston, TX whose son has epilepsy. The gentleman lost coverage not only for his family but all of his employees because of his son's high medical bills related to epilepsy. He wants to provide coverage for his employees but can't get that coverage.

The CHAIRMAN. Don't you think we ought to be able to try and work that out for even the smaller companies as well, so they are not devastated from an economic point of view, but also, so they face some responsibility in providing for coverage?

Mr. TILGHMAN. Yes, a solution needs to be found. As Congressman Gephardt said, many times the insurance premiums that people pay are designed to offset the costs of those who are getting free care.

The CHAIRMAN. I'll ask the staff to keep track of time, and we'll do 8-minute rounds.

Let me ask Sharon Burton what was the growth in the size of your households one who grew up in a big house with a lot of activity.

Mrs. BURTON. We have eight now.

The CHAIRMAN. And what did you have?

Mrs. BURTON. Just my husband and myself. I have two older daughters. I am, what you call, one of these mid-life (AK) mothers; at 39, I had another baby. Moving into Granny's house—she has a large house—we are still running into each other, but it is adequate.

The CHAIRMAN. Well, I just want to commend you. I think when you go from three up to eight—and I think you gave enormously powerful testimony with regard to the love and affection that is being shared by the members of the family—but it has to be enormously trying.

Mrs. BURTON. It is very, trying. When I walk in, and I see my grandmother, and she does not know who I am, and like I said, at the end of my testimony, to my grandmother I am "the girl" that takes care of her.

We play airplane. My grandmother right now probably soaking wet weighs 72 pounds. But every evening when I put her in bed, I will lift her legs and her head up, and I play airplane with her. I say, "OK, Granny, are you ready for your airplane ride?" And I just gently swing her into bed, and she just gets so tickled with that, and that brings the laughter. It is emotional, but yet like I said I would not want my grandmother or my Aunt Jane in a nursing home now, I realize my grandmother is going to get worse, and her life is limited—but my aunt is still there. So I gave up a quiet family life also for my aunt, because my aunt still has a long way to go.

The CHAIRMAN. Well, I just want to tell you how much I certainly respect you. It is a wonderful tribute to them to have someone like you, but it is wonderful tribute to you that you care so much about them.

Mrs. BURTON. Thank you.

The CHAIRMAN. I think this really is a natural transition. You mentioned something about education and the need for people to understand, and I think Sharon has indicated that she understands, but also faces those challenges of everyday life when a

parent or a loved one does not recognize you. And for Americans to understand what this is all about think you mentioned the need for that.

And if we look at the projections of what we are going to face with Alzheimer's with the growth of the elderly population in our society, it is clear this is going to be with us for a period of time.

You are in a situation, Mrs. Parekh, where you are caring for Alzheimer's individuals and others at the center, and then you are back home and caring for a member of your family who is affected by Alzheimer's; is that correct?

Mrs. PAREKH. That's correct. There are seven of us in our house. I have two daughters in college and one son in high school and a little girl in elementary school.

At first when Grandma came to live with us, there was hostility in the air because this was going to totally disrupt their lives in some shape or form. As I said in my prepared testimony, we have to become a society very quickly that assumes responsibility. Not one person can do it alone. It is the responsibility of all of us to look at what is going on about us.

If I look at it as a business woman, it is far cheaper to put into place programs that take care of people than to wait until they have to be hospitalized and put in ICC and in critical care facilities. So it is cheaper in the long run to take care of each other now instead of waiting.

The CHAIRMAN. My time is up, but I just want to tell you how much I admire your dedication and commitment to the nursing profession, and also the extraordinary personal commitment on your own to caring for people. It is really an inspiration.

Senator Durenberger.

Senator DURENBERGER. Mr. Chairman, just a comment. Let me express my gratitude to the witnesses for being here and sharing their experiences with us. It is a reflection on our challenge, I suppose. Taking on all the problems that face us seems insurmountable, but it is absolutely necessary to do it. You can't start sorting things out and say, well, this is more important than that. Everyone here has a different experience. Not only the pain of not having a ready solution, but the cost to society as a whole of not dealing with these problems is enormous. That is the lesson I take from these witnesses.

The other is the affirmation, Mr. Chairman, of the fact that we have grown up in a society in this country which, in an effort to spread the liability for the costs of medical care as broadly as possible, we have developed a hospital system that has also been a national health care insurance system because, at least until recently, if you can't pay, the hospital will do it for nothing. The same thing is true of other medical professionals. As long as the costs were not too high, we could use that system. Then we used employers to do the same thing. We said wouldn't it be nice if all the employers would pay for the health care insurance, and that spread across the whole universe, until the costs got too high, and we couldn't afford that anymore.

We have done the same thing to some degree with government, and so far none of the solutions to spreading the costs has worked very well, for a couple of reasons. One has developed, because by

spreading the responsibility for the costs we have also spread the responsibility for preventing a lot of illnesses in our society. We have spread the responsibility for taking care of ourselves. I don't know how many smokers I still meet on the way over here from my office.

So it seems to me, Mr. Chairman, that part of our burden here is to take up the challenge of financing access by changing the ways in which Steve and the rest of these people are able to financially access the system and to try to inject into that system as equitable a system of access as we can. I mean, if you are out of work, you are out of work. If you work for a little company that can't afford health insurance, that's just too bad. But if you work for the telephone company or some other big company in America, you are still getting free health care, and you are using it, and you are taking it away from somebody else.

The inequities in the access to health care were spoken of in education hearing yesterday and have been spoken of in health care today, and I think that is one of the forces that drives a lot of us on this committee, and certainly has driven the chairman ever since he's been here to deal with these subjects. So I think everyone here is committed, on whatever committees we sit and regardless of the resources that it takes.

I have a little bill called the small group insurance reform bill, which is intended to deal with some of the problems Steve said he was being exposed to and other people are being exposed to in terms of discrimination on the basis of a prior disability, or people who are so-called medically uninsurable only because they have had one incident, or a diagnosis, and so forth.

So I hope that as you go away from here, you know that your message has been replicated in various ways in our communities and that particularly the leadership on this committee and hopefully the members of the committee as well—and I am only speaking for myself—are really dedicated to dealing with the problems that you have brought to our attention today.

I thank you.

The CHAIRMAN. Senator Simon.

Senator SIMON. Thank you.

I want to thank all four of you for being here because I think you have helped us understand what is happening in this country.

How old are you, Chris?

Mr. CHRIS TILGHMAN. I am 13.

Senator SIMON. And you are a champion speller. Could you spell "Kennedy" and "Durenberger", do you think? [Laughter.]

Mr. CHRIS TILGHMAN. No, those never came up.

Senator SIMON. I might mention, Chris, one of the ablest members I served with when I was in the House was Congressman Tony Coelho, who has epilepsy. I think you understand that your future is not limited.

Mr. CHRIS TILGHMAN. Yes, sir.

Senator SIMON. I think it is great that you are a swimmer and bicycler, and I don't know what you are going to do in the future, but I think it is going to be good.

Mr. Tilghman, you mentioned that you went from a large company into your own business. Are you a sole practitioner, or do you have other employees?

Mr. TILGHMAN. I am basically a sole practitioner. In some projects that I am involved with, I have a partner who is also a CPA, but his wife works for a regional stock brokerage investment house, so he has coverage through her.

Senator SIMON. I think there is something our committee ought to look at. You are in a little different situation, but you mentioned someone who had a restaurant in Texas, I believe. People who have 10 employees, for example, have to pay very high insurance premiums because the base is so small. We ought to think about giving a small Grant to every State to provide for a competition among the private insurance companies, based on what they can do for, say, 40 cents an hour. Then the State of Alabama or the State of Massachusetts or whatever State it is could make that award to Blue Cross or Prudential or Mutual or whoever provides the greatest amount of service. Then any small business person who wanted to—it would be strictly voluntary—could take advantage of that premium, and you would have a broader base for the insurance coverage. I think something along that line is needed.

Mrs. Burton and Mrs. Parekh, I admire both of you for what you are doing. You mentioned one thing that interested me, Mrs. Burton. You mentioned that your grandmother has Alzheimer's, but then you said she also has pernicious anemia, and because of that she is entitled to home health care.

Mrs. BURTON. Yes, sir.

Senator SIMON. Are you suggesting that Alzheimer's does not entitle her to home health care, but pernicious anemia does?

Mrs. BURTON. That's right. With just the Alzheimer's, we are not entitled to any benefits through Medicare. But because of the pernicious anemia, which is a blood disorder, she was entitled to the home health aide who comes in and bathes her three times a week, and the nursing when we need a home nurse.

Senator SIMON. All right. I ask you this question because our colleague Senator Durenberger is on the Finance Committee, so we're going to lobby him here with that.

Mrs. Parekh, you said something that I think is important. You said this should be the responsibility of all of us. It should not just be a burden on the Tilghmans, the Burton and the Pares. In some way, all of us ought to share these burdens.

I come from a family that fortunately is in good health. We could pay a few more dollars to share the burden with those who face special problems. The sense of community we ought to develop much more as a Nation.

I thank all four of you for being here. I think you have helped us to see what we ought to do.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Adams.

Opening Statement of Senator Adams

Senator Adams. Thank you, Mr. Chairman. I particularly want to compliment you for holding these hearings. I would ask unanimous consent that my statement be placed in full in the record.

I want the witnesses to know that I am aware of your testimony, and unfortunately we are having to do some other things today that have taken some of us away and may take us away from time to time. I want to pledge to you that as chairman of the Subcommittee on Aging that one of our primary topics is going to be long-term and community-based home health care.

When you speak of Alzheimer's disease I know what you are talking about. My wife's mother recently died after 13 years of suffering. And you are absolutely right; Medicare provides little help for home health care.

So as Senator Simon and the Chairman put so eloquently, we have a deep commitment to this problem. I am particularly pleased that the House will also be focusing on long-term and community-based home health care. Its a pleasure to have Representative Gephardt here today.

We pledge to help as much as we can.

Thank you, Mr. Chairman. I have no questions of this panel, and I appreciate being here this morning.

[The prepared statement of Senator Adams follows:]

Prepared Statement of Senator Adams

"Condition Critical." The title of this hearing is no understatement. The health care crisis in this country is of epic proportions. I welcome this hearing and the attention and urgency it brings to the problem of the uninsured.

Senator Kennedy deserves much of the credit for making Congress and the country sit up and take notice of just how poor a job we are doing when it comes to providing adequate health care to millions of Americans.

Hearings like this have made us all painfully aware of the vast scope of the problem. The numbers are staggering: 37 million Americans have no health insurance. Many of these are children, many are single parents—often women. And contrary to conventional wisdom, the majority of the adult uninsured population work. American employers are offering fewer and fewer health benefits to fewer and fewer American workers. The heartbreaking and tragic stories of Americans denied "access" to health care puts a human face on the problem of the "uninsured."

What does the lack of access really mean? It means that millions of Americans receive no health care—until their health problems reach a crisis stage and they seek care or are brought to a hospital emergency room. Routine preventive health services do not exist for these Americans.

Creating access to our basic health care system will not be easy. Nor will it be cheap. In fact it is both complex and costly. is it worth it? You bet. American families deserve no less. The Federal Government must play a major role if we are to find a solution that will work.

I am proud to say, however, that absent direction from the Federal Government, Washington State through the efforts of my colleague Rep. Jim McDermott, has embarked on a landmark demonstration project to provide health care coverage for up to 33,000 uninsured Washington State residents through a new program called quite descriptively, The Basic Health Plan. The majority of the 18,000 participants in the Basic Health Plan are employed, but hold jobs that don't provide health care coverage for the employee or their children. Most others who participate are between jobs.

Any Washington State resident living in a county participating in the plan and whose income falls below 200 percent of the Federal poverty level is eligible for care. The majority of participants earn less than 125 percent of poverty. There is a modest sliding scale with the average cost for family coverage at $38 per month. The State picks up the lion's share of the financing which totalled about $37.5 million for 1989-1991.

Care is provided under contract through private providers and insurers in the State. The plan places a strong emphasis on preventive health services, pap smears, breast examinations, immunizations, and childhood hearing and eye tests. Coverage also includes hospital and emergency care, ambulance services, other necessary doctors visits, lab tests, and X-rays.

The Basic Health Plan, however, cannot solve the problem of the uninsured on its own. The problem is vast. There are approximately 785,000 uninsured Washington State residents, 450,000 of these people meet the Basic Health Plan's eligibility requirements. Yet we are able to serve only 25,000 individuals—or less than 6 percent of the total residents who are eligible to participate. We need to expand programs like this one. But my State and others need help—help from the Federal Government—in order to ensure that each and every American has access to basic health care services.

Another critical part of the access equation is the problem of long-term care. Quite simply, we need a long-term care system in this country. Not next year, or the year after, but now. Current demographic changes alone require us to address the changing health care needs of an aging society. As Chairman of this Committee's Subcommittee on Aging, I intend to take a long hard look at this issue. The Pepper Commission's recommendations represent an important and essential step toward a national long-term care policy.

One of my duties this year as Chairman of the Subcommittee on Aging is to reauthorize the Older Americans Act (FAA). The FAA plays an important role in providing home and community based long-term care services, but these services are sorely underfunded. In some cases, they are virtually non-existent. During the upcoming reauthorization process, I intend to examine the role the FAA should have in the development and management of a comprehensive system for home and community based long-term care.

Another area that I intend to focus on is the role of caregivers—both formal and informal, paid and unpaid—who provide care to millions of Americans unable to care for themselves. Caregivers, the majority of whom are women, who work for little or no pay, end up on with fewer retirement benefits, low Social Security earnings, and in poor health. I think these economic inequities need to

be addressed as part of the problem of expanding access to health care and the development of a long-term care system.

I want to close by saying that whatever role we develop for the Older Americans Act in the delivery of long-term care services, it cannot supplant the creation of a long-term care plan for the country. But I believe the FAA can be a part of the solution to insuring access to health care in America.

The CHAIRMAN. Well, again we want to thank all of you very, much. As I often say, it is very difficult to talk about health care challenges that families face. It is never easy, and we understand that, certainly, with all of you. But the fact that you have been willing to share that is enormously important for us, and hopefully, hundreds and millions of Americans across the country can identify with similar situations, and I think it just raises the ante, hopefully, for us to take some action.

We will do everything we can to try and do that.

We thank all of you very much.

Our next panel is a distinguished group of experts which represents a range of perspectives on the need for major health care reform. We welcome Martha Thornton, who is senior vice president of human resources for Ameritech Corporation; our second witness, Gail Shearer, is manager of the policy analysis division of Consumers Union; Alan Nelson is immediate past president of the American Medical Association; and finally, Lena Archuleta is a member of the board of directors of the American Association of Retired Persons.

We'll start with Ms. Thornton.

STATEMENTS OF MARTHA L. THORNTON, SENIOR VICE PRESIDENT, HUMAN RESOURCES, AMERITECH, CHICAGO, IL; GAIL SHEARER, MANAGER, POLICY ANALYSIS, CONSUMERS UNION, WASHINGTON, DC; DR. ALAN R. NELSON, IMMEDIATE PAST PRESIDENT, AMERICAN MEDICAL ASSOCIATION, SALT LAKE CITY, UT; AND LENA ARCHULETA, MEMBER, BOARD OF DIRECTORS, AMERICAN ASSOCIATION OF RETIRED PERSONS, DENVER, CO.

Ms. THORNTON. Good morning, Mr. Chairman.

I appreciate the opportunity to appear before this committee on an issue of vital national concern and to present the views of Ameritech on the health care cost problem facing American businesses.

Ameritech is one of the seven regional communications companies formed as a result of the breakup of the Bell System. We have 76,000 active and 45,000 retired employees, all of whom have noncontributory medical coverage. Adding their dependents, we provide health care benefits to about 250,000 people.

In 1989, our health care expenses were $337 million, or 28 percent of our net income. Almost one-third, or $100 million, was for retirees and their dependents. Total expenses were 13.3 percent more than in 1988, and for the five-year period ending in 1989, our annual increase averaged 10.4 percent, which represents less of an increase than many other employers and general insurance industry trends.

Our cost control efforts have focused on the effectiveness of expenditures and not shifting costs onto employees. We believe our experiences can be of value to other businesses, to government purchasers, and to Policymakers. Because of this we have been very active in business groups, such as the Washington Business Group on Health, and in coalitions such as the National Leadership Coalition for Health Care Reform.

Increasing access to medical care is a goal fully supported by Ameritech. At least in the short term, we expect this may result in increased public and some private expenditures. Ameritech believes that employment-based approaches are the preferred vehicle to expand coverage.

However, while employers can help employees, the ultimate responsibility to obtain coverage must rest with the individual. Government must continue to be the safety net for those without the financial means to access care and private plans. In addition it should remain the private payer for the elderly and the disabled through the Medicare program.

Access must not be dealt with in a vacuum. Additional reimbursement dollars without cost controls will exacerbate the current cost spiral. Cost control and quality improvement must be part of the solution. New approaches are necessary.

We strongly support the use of organized delivery systems and managed care, as they are showing that controlling costs is compatible with improving quality. Organized delivery systems consist of physicians, hospitals and others tied together by a commitment to deliver services effectively and efficiently to a given population.

The organization and its providers commit to continuous quality improvement to the delivery of services and, more importantly, the health status of the population being served.

Competition among these systems for contracts with employers, insurers and the government will force them to deliver care in ever more effective ways.

Public policy should encourage the development and use of organized delivery systems, particularly to improve access for the currently uninsured. Large employers are using this approach for their employees, including senior management. We are not advocating something for others that we are not willing to use ourselves.

For Ameritech, this means building on those aspects of our current plan which have contributed to lower than average growth in costs. This includes using the medical management and negotiated provider reimbursements of our local Blue Cross plans. Under the current plan, Blue Cross reviews medical care received by our employees and their dependents. Elective hospital admissions and a growing number of outpatient procedures are reviewed prospectively for their appropriateness and for the site of that service. All hospital admissions are reviewed for appropriateness of continued stay.

Organized delivery systems and managed care improve patient care as well as controlling expenses. Recently, physicians recommended hysterectomies for several Young women who were beneficiaries in our plans. These women were referred to other physicians by Blue Cross nurses and underwent nonsurgical alternative

treatments. These treatments alleviated their problem and allowed them to become first-time mothers.

Our plan also provides employees the option of a preferred provider network. These providers have agreed to accept negotiated fee schedules and, more importantly, to voluntarily adhere to medical management programs. This program has helped to control the growth in provider reimbursements in our plans. The plans cover prenatal care, well child care, and a select group of early detection services for adults including mammography and home health care benefits. These should have a positive payback, although over the longer term.

But we cannot rest on our past successes. Looking into the future we predict increasing health care costs and increasing trend rates. We need to control costs, but not shift these to our employees or jeopardize the quality of their care.

We recently announced that employees will be offered a new plan—an open-ended HMO or point of service plan. We have contracted with Blue Cross to offer a network of providers to eligible employees. Individuals will choose a personal care physician responsible for the coordination of primary and specialty care. Individuals can use the physician or hospital of their choice, but there will be incentives to use those participating in the network.

Blue Cross provides the systems necessary to manage cost, utilization and the quality of service, and is accountable to the company for their performance in this regard.

This approach is the first step toward the widespread adoption of organized delivery systems. It binds together the employer, the managed care intermediary and the providers to find common solutions to the problems of cost, quality and access. There will be a decreasing need for employers or others acting on their behalf to police the practice of medicine. The providers will be performing this role as a part of their contract and their belief in the need for peer oversight.

Laws encouraging utilization review, selective contracting arrangements, and other managed care approaches will help the success of organized delivery systems. This is a particular concern at the State level.

We see other ways for government to facilitate this transition; these have been included in our written statement.

In closing, I would like to thank you again for the opportunity to testify and to offer our assistance to the members of the committee and your staff in better understanding our approach to health care management. In addition, we would be pleased to work with you through the business organizations in which we have been participating.

Thank you.

The CHAIRMAN. Well, thank you very much. I think it is particularly important for someone who represents some 250,000 employees and have been able to do this and is also interested in expanded coverage; that is enormously important, and we'll come back to some questions.

Thank you.

[The prepared statement of Ms. Thornton follows:]

Prepared Statement of Martha L. Thornton

The Federal Government should encourage the development and use of organized delivery systems as the preferred way to offer quality medical care and to control rising health care costs. New private sector approaches, such as organized delivery systems bring employers, employees, and health care providers together in a cooperative effort.

Organized delivery systems consist of physicians, hospitals, and others linked by a commitment to deliver quality medical services to a particular group, such as a company's employees. This system unites the employer, the managed care intermediary, and the health care providers to find common solutions to the problems of cost, quality, and access to care.

Ameritech, a large communications company, headquartered in the Midwest, has adopted a managed health care plan, one type of organized delivery system. Our plan encourages employees to choose from physicians and hospitals in a network offered by the company's health plan administrator. Preferred providers agree up front to negotiated fees and certain medical management programs. Employees using these preferred providers are able to minimize their out-of-pocket medical expenses.

Ameritech's managed care plan has allowed the company to improve patient care and to realize below average growth in health care costs without shifting costs to employees.

The public sector has a vital role to play in helping provide health coverage to all Americans. Laws encouraging utilization review, selective contracting arrangements, and other managed care approaches will help the development of organized delivery systems. The Federal Government should increase its support of the evaluation of new and existing medical technologies, as well as fund research and act as a Clearinghouse for research results from the private sector. The government can help develop treatment guidelines for needed reform of the medical malpractice system. Government should remain the primary payer for the elderly through the Medicare program.

Enhancements to the existing health care delivery system should build upon the present employment-based system. Federal policy should not attempt to find a single approach to apply to all areas of the country, all population groups, or all medical marketplaces. As we find with our own company, there are differences, and we must provide choices to people.

INTRODUCTION

My name is Martha Thornton, Senior Vice President, Human Resources for Ameritech. I appreciate your invitation, Mr. Chairman, to appear before this committee on an issue of vital national concern, and to present the views of Ameritech on the health care cost problem facing American businesses.

Ameritech is one of the seven regional communications companies formed as a result of the breakup of the Bell System. In 1989, our net income was $1.2 billion. The company has 76,000 active employees, predominantly in five states: Illinois, Indiana, Michigan, Ohio, and Wisconsin. In addition, we have 45,000 retired employees. Ameritech provides medical coverage to all active and retired employees, and their dependents, approximately 250,000 people in total.

Our employee population has some interesting characteristics. It is an older work force, with an average age of 41.4 years. The average employee has 17 years experience with the company. Retirees leave the company with 32 years of service, on average, and at an average age of 57 years.

These service characteristics, combined with our commitment to provide medical benefits, makes management of medical benefits a priority for us.

In 1989, the company spent $337 million on health care, of which almost $100 million was for retirees and their dependents. Total expenses were 13.3 percent more than in 1988. For the 5-year period ending in 1989, our annual increase averaged 10.4 percent, which represents less of an increase than for many other employers and general insurance industry trends.

We have accomplished this by focusing on the effectiveness of our expenditures and not shifting costs to our employees. We have had the cooperation of our employees and the two unions which represent many of our employees, the Communications Workers of America and the International Brotherhood of Electrical Workers.

Ameritech has been actively involved in health care policy issues for several years. At the federal level, we are represented on the Board of the Washington Business Group on Health. As part of that group, we testified before Rep. Waxman's

health subcommittee about proposed changes to the federal Health Maintenance Organization (HMO) Act. We are also active in the National Association of Manufacturers, the U.S. Chamber of Commerce, and the National Leadership Coalition for Health Care Reform.

THE PROBLEM OF ACCESS

The annual increases faced by some companies have forced them to curtail health care coverage. State governments have tightened both eligibility requirements and reimbursement levels for public programs. These actions reduce access for the poor. Changes in Medicare reimbursement policy have placed a greater financial burden on the private sector through cost shifting. This is a hidden tax burden on the sick and those paying for care, which is not spread equitably across all taxpayers. As coverage becomes more difficult to obtain, care does as well.

Providing residents of this country with adequate health care protection is a policy goal which Ameritech fully supports. Achieving this goal is a complex matter involving a number of distinct but interrelated issues such as the extent of coverage available, the quality of care, and financing of care for the poor, to name a few. Although it is necessary to focus separately on each issue when developing legislative initiatives, it is equally important to place the interrelationships into the broad context of competing national goals.

Ameritech believes that employment-based approaches are the preferred vehicle to expand coverage. While employers can help employees, the ultimate responsibility must rest with the individual. We know from other employers that even in the presence of a plan provided and primarily funded by the employer, some employees choose to forego coverage. Employers should not be penalized for choices made independently by employees.

We must find ways to make coverage affordable for smaller employers and individual purchasers of health care plans. In particular, small groups must be able to benefit from the managed care programs available to larger groups. In addition, the many state laws which mandate coverage for particular classes of providers or treatments must be reviewed. Many of these mandates add to the cost of coverage without adding commensurately to the benefits to be gained.

To expand access to private plans for individuals not presently covered, we should be prepared to subsidize low-income groups to help ease the burden for them to purchase health coverage. In addition, individuals and unincorporated businesses must receive the same tax exclusion for medical benefits as for incorporated businesses.

Health care cost control has been an elusive goal for government, employers, labor, and individual consumers. We are all part of the problem, therefore we must be part of the solution.

Increasing access is very important, but cannot be discussed without attention to cost and quality of care issues.

ORGANIZED DELIVERY SYSTEMS—CONTROLLING COST AND IMPROVING ACCESS AND QUALITY

The existing medical delivery system is highly fragmented among various types of providers and sites of care. This inhibits coordination of services to patients, as there is no central person or organization taking full responsibility for managing all that occurs during a particular case." Most importantly, quality management and quality improvement activities cannot be carried out effectively under the current fragmented system. This is particularly true of care occurring in physician offices.

The Federal Government should encourage the development and use of organized delivery systems as the preferred way to deliver medical care and medical benefits. Such systems would be expected to supplant the current, fragmented regime.

Organized delivery systems consist of physicians, hospitals, and others tied together by a commitment to deliver services effectively and efficiently to a given population, such as employees of a company, or beneficiaries of a government program. The organization and its providers commit to continuous quality improvement aimed not just at the delivery of services, but, more importantly, aimed at improving the health status of the population being served.

Ameritech and many other national employers are heading in this direction, as are the national insurers, Blue Cross plans, and others. It is also the direction that public programs should be moving.

For Ameritech, it means building on those aspects of our current plan which have contributed to lower than average growth in costs. This includes using the medical management and negotiated provider reimbursements of our local Blue Cross plans.

Under the current plan, Blue Cross reviews medical care received by our employees and their dependents. All elective hospital admissions are reviewed prospectively for appropriateness of the procedure and for the site of service. All admissions, whether urgent or elective, are reviewed for appropriateness of continued stay while the patient is hospitalized.

While control of hospital usage is important for cost control, quality is also of concern. Patients receive valuable assistance selecting personally appropriate treatments and procedures.

Organized delivery systems improve patient care as well as help control expenses. For example, recently, physicians recommended hysterectomies for several Young women who are beneficiaries of our plan. These women were referred to other physicians by Blue Cross nurses and underwent non-surgical alternative treatments. These treatments alleviated their problems, and allowed them to become pregnant and first-time mothers. Had they followed the original surgical recommendation, pregnancy would not have been possible.

Our plan also provides to employees the option of using a preferred provider network, which gives employees financial incentives to use selected physicians and hospitals. These providers have agreed to accept negotiated fee schedules, and to voluntarily adhere to medical management programs of Blue Cross. This program has helped control the growth in provider reimbursements of our plans.

The plan covers pre-natal care, well child care, and a select group of early detection services for adults. These should have a positive payback, although over the long term.

We cannot rest on past success. We recently announced that employees will be offered a new plan—called an open ended HMO or Point of Service plan. This type of plan is becoming increasingly popular among large employers. National insurers, Blue Cross plans, or large health maintenance organizations, put together networks of providers, and the systems necessary to manage cost, utilization, and quality of services rendered to eligible individuals. While individuals have the option of using the physician or hospital of their choice, there will be incentives to use those participating in the network.

The physicians, hospitals, and ancillary providers are chosen according to criteria which examines their qualifications, such as Board certification, and their agreement to participate in medical management and quality improvement activities. The physicians, in particular, must be willing to have their office practices scrutinized by the networks.

This approach is the first step towards the widespread adoption of the organized delivery systems referenced earlier. It binds together the employer, the managed care intermediary and the providers, to find common solutions to the problem of cost, quality and access to care. There will be less need for employers, or others acting on their behalf, to police the practice of medicine of participating physicians, or the delivery of services in hospitals. The providers will be performing this role as part of their contract, and their belief in the need for peer oversight.

Organized delivery systems and managed care should be made available to smaller employers and be adopted for government programs as well.

Ameritech's senior management believes that these systems will enable us to better control our cost growth into the future without shifting costs to our employees. At the same time, our employees will have access to quality medical care and a quality benefit package.

A NEW MODEL OF CONSUMER CHOICE

The rise of organized delivery systems will allow employers to offer benefits programs which can be cost effective, yet promise better quality of care than the current fee-for-service system.

Employees will be able to choose from systems pre-selected by their employer. Employers will use competition among competing delivery systems to maximize the value of our expenditures and those of our employees. The competition to satisfy the employer and the employee will stimulate innovation and improvement of the delivery of care and the delivery of medical benefits.

Choice will not be the freedom to select from any and all plans or providers in a community, but from a smaller group pre-selected by one's employer, trust fund, or government program. This new concept of choice will be the only way to assure a balance of cost control, access, and quality of care.

THE ROLE OF GOVERNMENT

Government's primary role should be the creation of a legislative and regulatory structure which encourages certain activities and inhibits others, consistent with desired social policy. The Federal Government must set the parameters and ground rules within which we operate. Other principles of the government's role should include the following:

Laws encouraging utilization review, selective contracting arrangements, and other managed care approaches will help the development of organized delivery systems.

Government should not micro-manage the health care delivery system or the benefits delivery system, except to protect the health and safety of the public.

Government must continue to be the safety net for those without the financial means to access such plans. In addition, it should remain the primary payer for the elderly through the Medicare program. As stated earlier, we support the use of private health plans as the vehicle to expand coverage, and therefore access.

Government programs should be financed appropriately. Financing should be explicit and widely based. Use of taxes or surcharges on those with medical plans, such as premium taxes, or taxes on medical services, should be eliminated. This includes use of "All Payer" systems which place surcharges on hospital or physician bills to pay for uncompensated care.

Government must purchase health care, such as is done by the private sector. It should not shift its financial responsibilities to the private sector, nor should it use its legislative powers to systematically underpay providers.

Information is critical to appropriate decision-making, whether one is looking at an individual patient, or at a given population. We need to build on the efforts being made in various states to collect, analyze, and disseminate information about the Price, utilization, and quality of care. These data should be from public and private purchasers.

The Federal Government should increase its support of the evaluation of new and existing medical technologies. Technology should be defined in its broadest sense: equipment, pharmaceuticals, and procedures or techniques.

Technology evaluation includes development of practice guidelines or practice parameters. These can assist physicians and other providers of services to determine what works, or doesn't work, for particular diseases in particular patient groups. Put into language understandable by the patient, better individual decision-making could result.

Government support for technology evaluation studies can help determine which technologies would be disseminated to the community, as well as which would be withdrawn. In addition, payers can apply the information when making reimbursement decisions.

The government can help develop treatment guidelines for needed reform of the medical malpractice system. It has been shown in certain areas of the country that guidelines reduce malpractice premiums and the practice of defensive medicine.

Federal initiatives should fund research as well as be a Clearinghouse of results from the private sector. This would include initiatives such as those undertaken by the American Medical Association and various medical specialty societies.

It could also include projects like the planned trial of the Outcomes Management tools championed by Dr. Paul Ellwood. The trial is being conducted by a consortium of large national managed care firms and national employers, including Ameritech. This tool evaluates the effects of medical interventions by measuring the changes in a patient's ability to carry out his or her normal daily activities. From this, we will be able to determine whether the intervention improved, maintained, or decreased the patient's quality of life.

Federal policy should not attempt to find a single approach to apply to all areas of the country, all poulatl on groups, or all medical marketplaces. As we find within our own company, there are differences, and we must provide choices to people.

CONCLUSION

Increasing access to medical care through increased access to medical coverage is a goal fully supported by Ameritech. We believe that the business community wants to cooperate in the development of solutions which can improve the current situation. At least in the short term, we expect this will require increased public and private expenditures.

Access must not be dealt with in a vacuum. Additional reimbursement dollars without any cost controls will exacerbate the current cost spiral. Increased access cannot be accomplished independent of changes to the delivery of care, and without regard to the cost and quality of that care.

Cost control and quality improvement must be part of the solution.

Cost control is important for us and for all American industry as we compete here and abroad for business. While health care is an expense, it can also be viewed as an investment in our human resources. A productive work force is important, and effective health care contributes to building this competitive asset.

New approaches, such as organized delivery systems, bring the interested parties together in a cooperative effort. They do not put employers, government, or other third parties in the role of police officers trying to locate and root out bad apples. Organized delivery systems are showing that controlling costs is compatible with improving quality of care.

Public policy must encourage the development and use of organized delivery systems, which should be the preferred means to improve access for the currently uninsured. Large employers are using this approach for their employees, including senior management. We are not advocating something for others that we are not willing to do ourselves.

The success of organized delivery systems, and cost control in general, will depend on a body of knowledge about the effectiveness of various medical interventions, or the lack thereof. Increased government support of research in this area, and dissemination of results, will be critical.

Government must not use its legislative powers to shift its financial responsibilities onto others. Continued government underfunding of programs, inadequate provider reimbursement, and attempts to micro-manage health care delivery will undermine the private sector's efforts to provide quality health care to employees. We urge use of the same health care purchasing techniques for government beneficiaries as are used in the private sector.

In closing, I would like to thank you again for the opportunity to testify, and to offer our assistance to the members of the committee, and your staff, in better understanding our approach to health care management as well as general trends in the business community. In addition, we would be pleased to work with you through the business organizations in which we have been participating.

The CHAIRMAN. Ms. Shearer.

Ms. SHEARER. Mr. Chairman and members of the committee, Consumers Union appreciates the opportunity to present our views on the issues of increasing access to health care to all Americans. Consumers Union believes that these two issues should be very high on the domestic policy agenda of the 102nd Congress. I'd like to mention that with me today is Linda Lipton, our legislative counsel.

Consumers Union has supported the principle of extending access to high quality health care to all Americans for over 50 years. Consumer Reports recently published a two-part series, "The Crisis in Health Insurance", in the August and September 1990 issues. The reader response to this series has been overwhelming. Many readers wrote in to tell their own personal and compelling stories about health insurance problems.

Perhaps the most important point I can make today about the health care access problem is that it is a problem that affects everybody in this country. Everybody—rich and poor, employed and unemployed, male and female, Young and old—is at risk of being without health insurance. Even those of us who feel that our employer-provided policies protect us well could be just one illness or one accident away from losing both our health insurance and our savings.

The absence of universal access to health care hurts middle income consumers severely. Our article tells a story of a 47 year-old man in San Diego who went from a gainfully-employed, well-

insured law firm partner to a disabled accident victim with substantial gaps in health insurance coverage.

The middle class can be affected in many other ways as well. Since many employers have dropped or cut back on their health insurance benefits, many relatively well-paid employees, especially of small firms, may lack access to an affordable health insurance policy.

Consumer Reports tells the story of a small employer in California whose health insurance premium doubled in 1 year, with premiums for one employee of over $10,000 per year. Over half of the non elderly population without health insurance are working adults, and the spiraling health care costs are leading to high premiums that force the middle income consumer, both employees of firms and the self-employed, to drop coverage in too many cases.

Health conditions of some employees lead employers to either be locked into existing health insurance policies or to face difficult-to-accept exclusions from new policies. Other middle income consumers are affected because they are locked into their present jobs. Pre-existing health conditions and the fear of losing increasingly important health benefits keep them from being able to change jobs.

Also, working Americans can lose their health insurance when their employer goes out of business.

The lack of health insurance affects people's health and often has deadly results. Consumer Reports told the sad story of a man who died of malignant melanoma after treatment was delayed because he had to DeLay going to the doctor since he couldn't afford to pay another bill. He was not eligible for insurance from his employer until he had been on the job for a year.

In response to the Consumer Reports articles, one reader with an annual income of $11,000 wrote that a hospital would not perform his wife's needed cancer operation because of his inability to pay $7,000 up front.

Consumers Union supports a national health care program that provides universal access to high quality health insurance. Numerous proposals for how to solve the health access problem have been put forward. We have concluded that the best approach that could provide both universal access to high quality health care while controlling costs is the Canadian health care model.

The second issue I would like to address is long-term care, a key component of the country's health care crisis. Consumers Union does not believe that the private long-term care insurance market is capable of solving the Nation's long-term care problem problem that leads to poverty for many Americans. We support a social insurance solution to long-term care.

We believe that the private market cannot be expected to solve the Nation's long-term care problem for a number of reasons. Companies reject as many as 30 percent of applicants—those with higher-than-average health risks. Policies are expensive, costing up to $100 per month for a 65 year-old and much more for older applicants. Policies often restrict benefits for certain types of care such as custodial care, and consumers seldom understand the implications of the fine print in the contracts.

Failure to adequately protect against inflation is another major flaw of most policies. Another problem is the typical company policy of not providing a refund in the event that a policyholder discontinues the policy.

The private market is not well-suited to insuring the long-term care needs of people under age 65. Another deficiency of the market is unfair pricing practices. Most long-term policies are so-called "level premium" policies. This doesn't mean that the premiums will remain level; it means that premiums will not automatically increase each year as the policyholder ages. This amounts to a "bait, lock-in and switch" for consumers who are forced to make a purchase decision without knowing the costs in future years.

Unscrupulous insurance company and agent practices have also created major problems for consumers.

All of these considerations affect the appropriateness of private long-term care insurance for individual consumers. From a public policy perspective, however, there is one overriding consideration that affects whether the private market can solve the problem—affordability. Very few Americans can afford to buy a long-term care policy, especially if it includes the consumer protections that we believe are essential.

Consumers Union believes that the government needs to take an active role in solving the long-term care problem. In my statement I have outlined the parameters that we believe should guide a social insurance program.

When Consumer Reports looks at the Nation's health care system in the year 2000, we hope that the 102nd Congress will be commended for designing a system that assures high quality health care for all Americans.

Thank you very much for the opportunity to testify.

[The prepared statement of Ms. Shearer follows:]

Prepared Statement of Gail Shearer, Manager, Policy Analysis, Consumers Union

Summary of Consumers Union's testimony on Financing of Access to Health Care and Long-Term Care

Consumers Union strongly supports a program that provides universal access to high quality health care.

—All Americans—the poor, the middle class, the well-to-do—are at risk of being without health insurance. Even healthy individuals with employer-provided health insurance could be an accident or an illness away from personal bankruptcy.

—The lack of adequate health insurance can have serious health consequences and can even lead to premature death.

—The health access problem has many dimensions including: the need to control the spiralling costs of health care; affordability of premiums; the incentives that insurance companies have to deny coverage for high health risks; cost shifting that increases the cost of health insurance to cover the cost of unpaid hospital care; exclusions for pre-existing conditions; financial barriers that prevent prenatal and other important preventive care; the inability of the private market to deal adequately with small employers.

—Elements of a successful approach to expanding health access include: universal access; progressive financing; built-in cost-containment and quality-control; and elimination of administrative waste.

Consumers Union has major concerns about the ability of the private long-term care insurance market to meet consumers' needs and supports a social insurance solution to the long-term care problem.

—Some key problems with the private market include: availability to people with existing health conditions; fine print that restricts benefits; use of "gate-keeping" techniques such as "prior hospitalization" that severely limit protection; failure to protect adequately against inflation; inability to provide protection to children and Young disabled adults; incentives for companies to underprice their so-called "level premium" policies in the early years; unscrupulous practices such as "post-claims underwriting" when companies check a policyholder's medical history only after a claim is filed; and inability of the private market to protect a large share of the population because of the high cost of policies.

—Parameters to guide the ideal long-term care program include: coverage to protect people of all ages; progressive financing; comprehensive and universal coverage; a self-funding requirement; minimization of administrative costs; cost sharing that does not impose undue hardship; built-in cost control and quality control; equitable cost-sharing between generations; effective regulation of the private market; and minimization of public costs while meeting consumers' needs.

Mr. Chairman and Members of the Committee, Consumers Union[1] appreciates the opportunity to present our views on the issues of increasing access to health care and long-term care to all Americans. We salute the tireless efforts of the Chairman over several decades to improve access to health care. Consumers Union has endorsed many health insurance bills that bear your name. My written statement addresses first the issue of access to health care and second the issue of long-term care. These two issues should be very high on the domestic policy agenda of the 102nd Congress.

Access to Health Care

Consumers Union has supported the principle of extending access to high quality health care to all Americans for over 50 years. In 1939, Consumer Reports noted that 40 million Americans received inadequate medical care and called for enactment of the Wagner National Health Bill, which would have been a "cornerstone for a national health program."[2] This article concluded: "It has become obvious that the people of the country intend to see to it that the whole population shall benefit from the discoveries of modern medical science. The only question before the country now is "how soon?" In 1946, Consumer Reports supported the Wagner-Murray-Dingell Bill, which would have established federal compulsory health insurance.[3] In 1975, Consumer Reports published a comprehensive comparison of five proposals for "national health insurance" and established five goals that a national health insurance plan must meet to serve the consumer interest.[4] Most recently, Consumer Reports published a 2-part series, The Crisis in Health Insurance, in the August 1990 and September 1990 issues. (A copy of the recent articles is attached to my testimony). The reader response to this series has been overwhelming. Many readers wrote to tell their own personal compelling stories about health insurance problems.

As our recent series showed, the problem of inadequate access to health insurance is extremely complicated. Some of the highlights that merit emphasis include:

All Americans are at risk of being without health insurance. Without a system that guarantees universal access to health insurance, everybody—rich and poor, employed and unemployed, male and female, Young and old—is at risk of being without health insurance. Nobody is safe! Even those of us who feel that our employer-provided policies protect us well could be just one illness or one accident away from losing both our health insurance and our savings. Our August 1990 article tells the story of David Cur Now, formerly a partner in a San Diego law firm. He was in-

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[1] Consumers Union is a nonprofit membership organization chartered in 1936 under the laws of the State of New York to provide information, education and counsel about consumer goods and services and the management of family income. Consumers Union's income is derived solely from the sale of Consumer Reports, its other publications and films. Expenses of occasional public service efforts may be met, in part, by nonrestrictive, noncommercial contributions, grants and fees. In addition to reports on Consumers Union's own product testing, Consumer Reports, with approximately 5 million paid circulation, regularly carries articles on health, product safety, marketplace economics, and legislative, judicial, and regulatory actions which affect consumer welfare. Consumers Union's publications carry no advertising and receive no commercial support.

[2] The Wagner Bill & Mr. Gannett," Consumer Reports, April 1939, p. 20 and "'By Popular Demand," Consumer Reports, February 1939, p.32.

[3] "Bureaucracy in Medicine?," Consumer Reports, April 1946, Pp.110–111.

[4] "National Health Insurance: Which Way to Go?" Consumer Reports, February 1975, Pp. 118–124.

jured in an accident, when (while riding his bicycle) he was struck by an uninsured motorist. While his insurance carrier paid most of his bills (which totaled nearly $250,000), he has considerable out-of-pocket costs for home-health aide services he needs every day. But before long, his health insurance benefits will run out. Eventually he will qualify for Medicare because of his disability, but he will be unable to get coverage for expenses not covered by Medicare. If he is able to return to work, it is not very likely that he will find a firm that has an insurance company wiling to accept a less-than-perfect health risk.

Inadequate access to health care is a major problem facing the middle class. While there is growing understanding that a large percent of the poor have inadequate health insurance and limited access to health care, recognition that the health access problem is a major problem for the middle class is more recent. The case above of a law firm partner shows how an accident can suddenly create a health insurance problem for someone who not long ago wash a gainfully employed healthy person. The middle class can be affected in many other ways as well. Since many employers have dropped or cut back on their health insurance benefits, many relatively well-paid employees, especially of small firms, may lack access to an affordable health insurance policy. Consumer Reports tells the story of a small employer in California whose health insurance premiums doubled in one year, with premiums for one employee of over $10,000 per year. Over half of the non-elderly population without health insurance are working adults. And the spiralling health care costs are leading to high premiums that force the middle income consumer—both employees of firms and the self-employed—to drop coverage in too many cases. Consumer Reports noted that 48 percent of the low-wage members of the Service Employees International Union (whose members are hospital workers, janitors, and government employees) were offered insurance but turned it down because they could not afford the premiums. Health conditions of some employees, like Kay Nichols (who, at age 38, has glaucoma) lead employers to be either locked-into existing health insurance policies (unable to shop around for a lower-priced policy) or to face difficult-to-accept exclusions from new policies. Other middle income consumers are affected because they are locked-in to their present job; pre-existing health conditions and the fear of losing increasingly important health benefits keep them from being able to change jobs. Also, working Americans can lose their health insurance when their employer goes out of business.

The lack of health insurance affects people's health and often has deadly results. Consumer Reports told the sad story of John Andrusyshyn who died of a malignant melanoma, after treatment was delayed because he delayed going to the doctors since he could not afford to pay another bill. He was not eligible for insurance from his employer until he had been on the job for a year. There are many tragic examples of family tragedies of premature births that could have been prevented by adequate prenatal care. In response to Consumer Reports articles, one reader (with an annual income of $11,000) wrote that a hospital would not perform his wife's needed cancer operation because of his inability to pay $7000 front.

The health care problem has many dimensions. As the Members of this Committee know too well, the health access problem has many dimensions, including: the critical need for controlling costs, the present incentives for the private market to reject high risks and to dramatically increase premiums for groups with high claims, cost shifting (which transfers the $8 billion cost of unpaid hospital care to health insurance premiums paid by employers and their employees), affordability, special problems facing small groups, exclusions for pre-existing conditions, financial barriers that keep pregnant women from getting pre-natal care, and incentives for doctors to seek advice on creative bill coding in order to circumvent ceilings on reimbursement levels.

It is especially troubling that many Americans painfully become educated about the inadequacies of our health care system when they already have major problems on their hands: a severe accident, an acute illness, the development of a chronic health condition, the loss of a job. It seems especially unfair to burden people with what amounts to an unsolvable problem for them just when they are facing other major crises.

Consumers Union supports a national health care program that provides universal access to high quality health insurance. Numerous proposals for how to solve the health access problem have been put forward. Consumer Reports concludes that the best approach that could both provide universal access to high quality health care while controlling costs is the Canadian health system model. We urge this Committee to give this approach serious consideration. Elements of a successful approach to expanding health access include:

—Access should be universally available to all Americans;

—Financing should be progressive;
—Cost containment must be built-in to the system;
—Administrative waste should be eliminated; and
—Mechanisms to ensure quality of care must be integrated into the system.

During the past 50 years, health care expenses (as a percent of gross national product) have grown rapidly. In 1940, national health expenditures were 4.0 percent of GOP.[5] The percent Rose to 8.3 in 1975, and to 11.1 in 1987.[6] The corresponding figure (in 1986) for Britain is 6.2 percent, for Canada is 8.5 percent, and for Germany is 8.1 percent.[7] If present trends continue, health care will consume 15 percent of GOP in the year 2000.[8] It is clear that waiting longer is not going to make the problem any easier to solve. This is not a problem that will go away by itself if Congress fails to act.

Long-Term Care

The second issue that I would like to address is long-term care, a key component of the country's health care crisis. In May 1988, Consumer Reports rated 53 private long-term care insurance policies The October 1989 issue of Consumer Reports updates the earlier article In January 1989, Consumers Union issued the report: *Long-Term Care: Analysis of Public Policy Options,* which analyzes many of the issues that this Commission is addressing. I have submitted copies of the articles and the report for the record. In May, Consumer Reports plans to publish a comprehensive new analysis of how the private long-term care policies are evolving. We will provide the updated report to the Committee as soon as it is available.

In my testimony, I will describe many of the reasons why Consumers Union does not believe that the private long-term care market is capable of solving the nation's long-term care problem. I will also present some of the key reasons why Consumers Union supports a social insurance solution to long-term care and ten consumer-oriented parameters that should guide the Congress.

Role of the Private Long-Term Care Insurance Market. Consumers Union believes that the private market can not be expected to solve the nation's long-term care problem for a number of reasons. Companies reject as many as 30 percent of applicants, those with higher than average health risks. Policies are expensive, costing up to $100 per month for a 65-year-old, and much more for older applicants. Policies often restrict benefits for certain types of care (*e.g.*, custodial), and consumers seldom fully understand the implications of the fine print in the contracts. "Gatekeeping" techniques, whose role is to screen worthy beneficiaries from those who do not qualify for benefits are imperfect; while many policies are turning away from "prior hospitalization" requirements (which had the effect of denying protection to roughly 60 percent of nursing home entrants), many are using "activity of daily living" (ADL) screens. ADL's look at a patient's ability to perform routine daily activities such as eating and bathing. Even ADL's are far from perfect. One problem with ADL's is that many people with Alzheimer's disease do not have serious ADL limitations. Another problem is that definition and measurement of ADL's can vary, resulting in a large variation (45 percent) in how many people in a community with serious ADL limitations actually qualify for a policy.[9]

Failure to adequately protect against inflation is another major flaw of most policies. While more companies offer an inflation rider now than in 1988, many of the riders are limited. We do not believe that policies with modest (but limited) benefit increases protect adequately against inflation. For example, a policy with a 5 percent per year increase for 10 years (less if the policyholder reaches a certain age) leaves a 20-year policyholder with inadequate protection against high inflation levels. A 7 percent per year inflation rate in policy years 10 through 20 would cut the policy benefits in "real" terms in half.

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[5] Robert R. Henderson, M.D, *Health Care in the United States*, Metropolitan Insurance Companies, 1982, p. 15.

[6] *Source Book of Health Insurance Data*, Health Insurance Association of America, 1989, p. 49, quoting U.S. Department of Health and Human Services, Health Care Financing Administration, Health Care Financing Review, Winter 1988.

[7] *Ibid.*, p. 48.

[8] For the Health of a Nation: A Shared Responsibility, Report of the National Leadership Commission on Health Care, Health Administration Press Perspectives, Ann Arbor, Michigan, 1989, p. 3.

[9] Joshua M. Wiener, Ph.D., "Standards for Private Long-Term Cared Insurance; How Tough and Whose Job?," Testimony before the Subcommittee on Health, Ways and Means Committee, U.S. House of Representatives, May 17, 1989.

Another problem is the typical company policy of not providing a refund in the event the policyholder discontinues the policy.[10] Policyholders who drop their policy, perhaps to buy a better policy, are typically out of luck. We believe that policyholders who drop their policy after a certain amount of years of paying premiums should be eligible for some sort of compensation (*e.g.*, a cash refund or a reduced benefit), since early year premiums are used to subsidize later year risks.

The private market is not well-suited to insuring the long-term care needs of people under age 65. The Pepper Commission heard the compelling stories of a family who struggles to meet the daily needs of a husband crippled by multiple sclerosis and of a family whose child requires round-the-clock access to medical care because of a birth defect. Long-term care insurance is unable to help families like these who are in need today, or other Young families who are at risk of having long-term care needs before the age of 65.

Furthermore, the private market is expected to divert 40 to 50 percent (or more) of premiums collected to cover administrative and marketing costs, and profits. In contrast, the Medicare system spends 97 percent of revenues on benefits.

Another deficiency of the private market is unfair pricing practices. Most long-term care policies are "level-premium" policies. This does not mean that premiums will remain level. It means that premiums will not automatically increase each year as the policyholder ages. Companies with "guaranteed renewable" policies are free to increase the so-called level premium if they increase it for everyone else in the state with the policy. This amounts to "bait, lock-in and switch" for consumers, who are forced to make a purchase decision without knowing the cost in future years. This leads to strange incentives for insurance companies. Companies have a strong incentive to underprice the policy initially in order to attract customers, and then raise premiums in later years, once consumers are locked in.

Unscrupulous insurance company and agent practices have also created major problems for consumers. The October 1989 issue of Consumer Reports tells the story of three victims of the troubling practice of "post-claims underwriting"—the practice of checking a policyholder's medical history only after a claim is filed, instead of when an application is taken. It is very difficult for a consumer to predict at the time of purchase whether the company is likely to honor a legitimate claim made in the future.

All of these considerations affect the appropriateness of private long-term care insurance for individual consumers. From a public policy perspective, however, there is one overriding consideration that affects whether the private market can solve the problem—affordability. Even under optimistic assumptions about people's willingness to buy policies, the Bookings Institution estimates that a fairly limited private insurance policy could be purchased by only 25 percent of the elderly by the year 2018 and that such coverage could make an insignificant reduction in Medicaid long-term care expenditures, reducing the number of nursing home patients whose expenses are covered by Medicaid by only 2.3 percent in 2018.[11]

Therefore, we recommend that the Congress reject options that would promote private long-term care insurance by preferred tax treatment for individuals or by tax preferences. This type of approach would inevitably collect tax revenues from a broad range of income groups, and provide additional private long-term care insurance (with the limitations noted above) to relatively high income people. While Consumers Union is working with the National Association of Insurance Commissioners on their efforts to improve the regulation (and the performance) of the private long-term care market, we recognize that these private market is incapable of protecting a large percent of Americans. While improving the market will help a small number of consumers who are able to afford costly policies, it is crucial that Congress shape a long-term care program that will extend protection to people of all income levels and of all ages.

Support for Social Insurance Long-Term Care Program. Consumers Union believes that the government needs to take an active role in solving the long-term care problem. The parameters that should guide development of a social insurance program are:

—The program should protect people of all ages;
—The program should be financed progressively;
—The program should be comprehensive and universal;
—The program should be self-funded;

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[10] In insurance parlance, this issue is referred to as "nonforfeitures values."

[11] Alice M. Rivlin and Joshua M. Wiener, *Caring for the Disabled Elderly—Who Will Pay?*, The Bookings Institution, 1988, p. 77 and p. 80.

—Administrative costs should be minimized;
—Cost-sharing should be an integral part of the program, but should not impose undue hardship;
—Cost control and quality control should be built-in to the program;
—Costs should be shared equitably between generations;
—Regulation of the private market should be effective and strictly enforced; and
—Public costs should be minimized while meeting consumers' needs.

Each of these parameters is explained in detail in Consumers Union's January 1989 report, *Long-Term Care: Analysis of Public Policy Options.*

Consumers Union fervently hopes that this Congress will act decisively to provide all children' with access to health care, to assure that all pregnant women receive pre-natal care, to expand access to health care to all of the poor and to people of all income levels, to prevent Americans of all ages from being impoverished by the high cost of nursing home or home health care needed on a long-term basis, to end the out-of-control spiralling of health care costs, to create a health care system that meets the differing needs of every American. Congress has considered proposals to address these concerns for at least the past 50 years. We look forward to working with this Congress to finally shape the solution to these problems. When Consumer Reports looks at the nation's health care system in the year 2000, we hope that the 102nd Congress is commended for designing the system that assures access to high quality health care for all Americans.

Thank you very much for the opportunity to testify today.

A REPRINT FROM **CONSUMER REPORTS** MAGAZINE

Consumer Reports

PART 1

THE CRISIS IN HEALTH INSURANCE

- **WHO LOSES IT? WHAT HAPPENS?**
- **WHICH POLICIES ARE BEST?**

A reprint from the August 1990 issue of Consumer Reports magazine.

RO101

THE CRISIS IN HEALTH INSURANCE

In the U.S., the ticket to health care is insurance. If you are in good health and have a well-paying job with a large firm, chances are you have a ticket, and your employer pays for it. But if you work for yourself, have a low-paying job, or are sick, chances are you'll have to pay for the ticket yourself—if you can buy one at all.

Tickets are becoming harder to get. Between 31 million and 37 million people have no health insurance, either because they can't afford it or because insurance companies refuse to sell them a policy at any price.

Others lose their tickets. People who once had insurance may suddenly find themselves without it when employers discontinue health-care coverage or go out of business; or when insurance companies cancel policies or become insolvent.

Millions more have no protection against a catastrophic illness. They may have some insurance, but lack coverage for the very conditions that will one day require unusually heavy expenditures.

"If the employed population knew how vulnerable they were, they'd be up in arms demanding national health insurance," says Bonnie Burns, a counselor with California's insurance counseling program. "Most of these people are three paychecks away from disaster."

The health-insurance crisis is a fairly recent phenomenon. At the beginning of World War II, few Americans owned a health-insurance policy. As recently as 1965, most had coverage only for hospital stays. The health-insurance system as we know it today evolved in the 1960s and 1970s. Under that system, workers came to expect their employers to supply medical coverage for them, with employers and employees splitting the cost.

That worked well for a while. More workers had health insurance, and their coverage broadened to include doctors' visits, prescription drugs, and even treatment for mental illness. But now the system stitched together over the last 50 years is unraveling, and people are being deprived of needed health care.

In this, the first of a two-part report, we look at why people lose their health coverage, and we rate the major medical and hospital-surgical policies that are available to individuals—a temporary remedy for some people. Part Two examines some possible cures for the health-insurance crisis.

WHO LOSES IT? WHAT HAPPENS?

People without health insurance include men and women who work for small businesses, the self-employed, part-time workers, young people just starting their careers, the disabled, the divorced, and those taking early retirement but still too young for Medicare. Some of the uninsured are also poor. Medicaid, the Federal and state program that covers medical expenses for the indigent, currently pays the bills for only 38 percent of the nation's poor.

People without health insurance may not get medical care. One million families each year try to obtain care when they are sick, but cannot afford to pay for it. Even if they are not ill, people without insurance postpone preventive care until more costly treatment is necessary—or until it's too late.

Two-thirds of all people with hypertension fail to have their disease controlled, largely because they can't afford medications. Half of those with hypertension haven't seen a doctor within the past year. A Roper poll has found that the proportion of Americans going to doctors in any one month has fallen to a 15-year low.

Women are particularly at risk. Uninsured women are much less likely than insured women to have screening tests for breast and cervical cancer or for glaucoma. If they are pregnant, they often do without prenatal care. Some five million women between the ages of 15 and 44 are covered by private health-insurance policies that don't include maternity coverage.

Photos: CYNTHIA JOHNSON

Crisis: Delayed care

John Andrusyshyn worked in a Nevada casino. Three summers ago, he noticed a mole growing on his chest, but said nothing about it to his family. He could not afford to pay another bill, so he put off seeing a doctor. Andrusyshyn was not eligible for insurance from his employer until he had been at his job for a year; he couldn't afford his own coverage on the $880-a-month he was bringing home to support his wife, Karen, and two children, Laura and Nikolai (pictured at right).

Several months went by before Karen insisted he go to a doctor. Because dermatologists in Reno were booked up, three more months passed before a doctor examined him. By then, the mole had ulcerated, and John was so desperate for treatment he paid for the visit with a bad check.

The diagnosis was a malignant melanoma that was already coursing through his body. By the time he underwent surgery, he was eligible for insurance from the casino. But Karen had to scrape together $56 a week to pay his share of the premiums, forgoing food and other necessities. The policy covered the hospital bill, but not the $4000 surgeon's fee. On John's medical records, doctors noted: "Patient has no money; we'll do the best we can."

Soon afterward, the Andrusyshyns traded in their mobile home for a '62 Airstream trailer plus $1500 in cash, borrowed a credit card from a relative, and headed for Canada where John was born. As a Canadian citizen, he was entitled to free medical care. In Montreal, doctors tried various cancer treatments, including brain surgery, which he could not have paid for in Nevada. But treatment came too late. Last fall, at the age of 54, John Andrusyshyn died.

"Had we had the medical care available in Nevada like we have here, he would have said something to me," Karen says. "A little thing like an early diagnosis could have added four or five years to his life. That would have meant a lot to this family."

Lack of prenatal care translates into babies who are too small when they are born and babies who die soon after birth. The U.S. trails 23 other nations in the percentage of babies born with an inadequate birth weight and ranks 22nd in the rate of infant mortality, behind such countries as East Germany, Spain, and Singapore.

Shifting the cost

When the uninsured are able to obtain health care, everyone pays. Each year thousands of people are dumped into emergency rooms of public hospitals because private hospitals don't want patients who can't pay.

In 1988, unpaid hospital bills totaled more than $8-billion, up 10 percent from the previous year. To recoup the costs of unpaid care, hospitals and doctors simply raise their fees to those who do pay—primarily the private insurance carriers and the Federal government.

Such cost-shifting drives up the price of insurance, resulting in even more people who can't afford coverage. In New Jersey, for example, every hospital bill now carries a 13 percent surcharge, reflecting the hospital revenue lost to unpaid bills. That, in turn, feeds into higher insurance premiums.

Cost-shifting accounts for about one-third of the increase in insurance premiums, which are rising as much as 50 percent a year. The cost of medical care—which is increasing two to three times faster than the rate of inflation—is responsible for the rest.

Unaffordable premiums

The higher the price tag for insurance, the more people who go without it. Firms with fewer than 100 workers employ about one-third of the work force in the U.S., but only about half of them offer health insurance to their employees. Small-business owners say they have enough trouble staying afloat without assuming the heavy burden of health-insurance premiums.

Even when employers do offer coverage, not all their employees take it. The Service Employees International Union, whose members are hospital workers, janitors, and government employees, found that 48 percent of its low-wage members were offered insurance but turned it down because they could not afford the premiums. In 1987, 25 percent of the uninsured worked for very large employers, most of whom offered health insurance.

People who want coverage and must buy it on their own have little choice but to pay what the insur-

ance company demands. In many instances, that can mean thousands of dollars each year. And premiums continue to rise dramatically.

Consider Stephen Beidner, a part-time worker at a California winery. When he first took out a policy with a company called Consumers United Insurance in 1985, he paid $912 a year. By 1989, his premium had jumped to nearly $3600.

In 1989, after Beidner had arthroscopic surgery for a knee injury, the company hiked his premium a whopping 93 percent to $6900. After Beidner protested, the company reconsidered his case and let him raise his deductible from $100 to $1000. His new premium: $2177 a year.

Less coverage for many

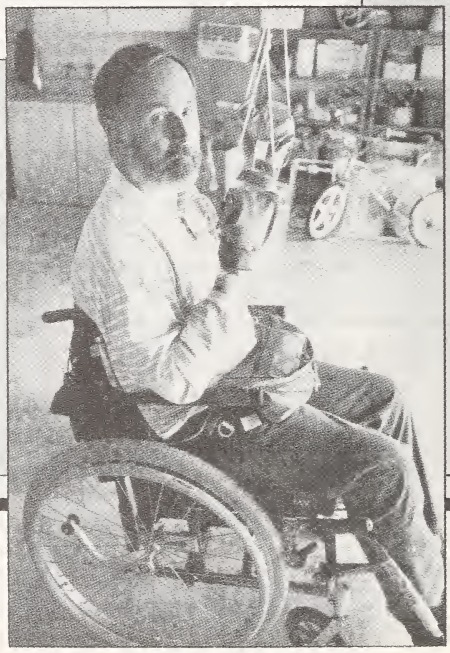
Beidner is hardly alone in having to settle for less coverage. Spiraling premiums also affect millions of people whose employers provide their health insurance.

One major employee-benefits survey found that employers now spend an average of $2700 annually to cover each employee. In many cases, employers are shifting some of those ever-increasing costs to their workers by requiring them to pay a greater share of the premium and a larger portion of their medical expenses through higher deductibles and copayments. Other companies, such as American Airlines, try to reduce their insurance bill by refusing to cover preexisting health conditions for new employees.

In 1984, Hewitt Associates, a benefits consulting firm, found that 37 percent of large employers paid the full premium for their workers. By 1988, that figure was down to 24 percent. In 1984, 53 percent of large firms paid all hospital room-and-board charges for their workers; in 1988, the figure was 29 percent.

Losing coverage

About half of all large- and medium-sized firms try to trim their



Crisis: Benefits end, costs don't

David Curnow, 47, was a partner in a San Diego law firm. One Saturday, while riding his bicycle, he was struck by an uninsured motorist. After two months in intensive care, Curnow emerged a quadriplegic, paralyzed from the chest down.

His law firm had self-insured its employees' health coverage, agreeing to cover the first $7500 of a worker's claim, and paying premiums to an "excess-risk carrier" to cover the rest.

After the first $7500 was paid, the carrier refused to pay its share of Curnow's bills. Months passed. Doctors, hospitals, and companies providing necessary medical supplies dunned Curnow for payment.

Eventually the carrier paid most of Curnow's bills, which totaled nearly $250,000. But he is still waiting to be reimbursed for the services of the home-health aide he needs every day. The third-party administrator handling his case told him those services were covered, but so far, the cost—some $1500 each month—comes out of his pocket.

Curnow has another problem—how to pay for his continuing medical bills when insurance benefits from the law firm run out. If he doesn't work again, his disability will eventually qualify him for Medicare. But he will still have no insurance for services Medicare doesn't cover. Nor will he be able to buy any. Companies usually don't sell Medicare-supplement policies to the disabled under age 65. If he goes back to work, he must find a job in a large law firm whose insurance company doesn't require employees to be in perfect health. If he opts for a conversion policy from the company now insuring employees in his old firm, he will have to pay $6000 a year.

"How many sick and disabled people do you know who can afford to pay $6000 a year for health insurance?" he asks.

insurance outlays by self-insuring. They invest the money they would otherwise spend on premiums and pay employees' claims directly when they arise.

The Employee Retirement Income Security Act (ERISA) exempts these self-insured plans from state insurance regulations meant to protect consumers. For example, employers may not have to offer certain coverages, such as care for newborn children, or provide for continuation of coverage when employees leave.

Employers hire a third-party administrator, or TPA, to handle the claims. Because the administrator may be the local Blue Cross plan, employees may think that Blue Cross (or some other insurer) is actually underwriting their coverage. Little do they know that the loopholes created by ERISA can leave them without insurance if things go wrong.

If the employer goes out of business or drops the coverage, employees could be out of luck.

The woes at HMOs

When a health maintenance organization closes its doors, the people who received medical care there may also be left uninsured.

Established as alternatives to traditional insurance policies, HMOs provide a variety of prepaid health services to their members . Unfortunately, a number of HMOs have fallen on hard times.

Several states don't require conversion policies or continuation of coverage for members whose HMO has gone out of business. Even in states that do, HMO members have no assurance that their new coverage will be anything like the old. They may well find themselves assuming a greater portion of their medical expenses.

Consider what happened to Samuel Stroup. A former home-improvement salesman in Akron, Ohio, Stroup underwent a liver transplant at the same time that Maxicare, his HMO, was going bankrupt. Stroup went ahead with the transplant because the firm handling Maxicare's affairs approved the procedure and agreed to pay for the antirejection drugs he would need following the operation.

After the bankruptcy filing, Blue Cross and Blue Shield of Ohio took over Maxicare's subscribers. Stroup assumed that his $12,000 annual drug bill would be covered for the rest of his life. But Blue Cross had other ideas. It offered Stroup, who had turned 65, a Medicare-supplement policy that covered his drugs only after he paid a $2500 deductible and $1000 in coinsurance.

Stroup and his wife must now pay some $7000 a year for insurance premiums and drugs out of their $10,000 income from Social Security disability. They expect their $60,000 life savings to be depleted in 3½ years.

Clinging to coverage

Millions of Americans have yet to lose their insurance but could at any time fall victim to an insurance company's business practices. As health-care providers continually raise their fees and pass on the higher cost of medical care to insurance companies, the companies respond by insuring fewer people. People who must buy coverage on their own and workers in small firms feel this pinch the hardest.

Insurance companies are not charities. Their goal is to make a

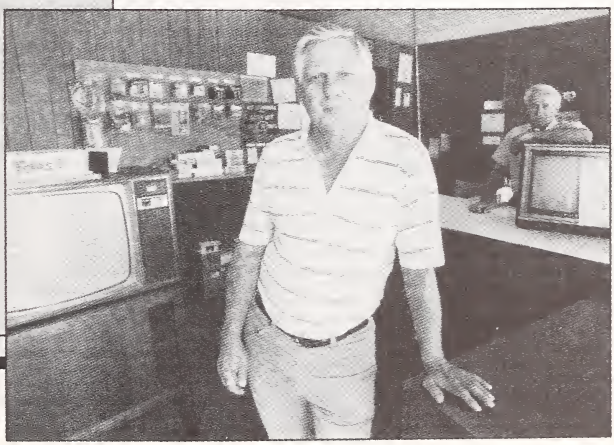
Crisis: Unaffordable premiums

Lloyd Pudiwitr owns a TV repair shop in Bakersfield, Calif. He has seven full-time employees and one part-timer. For years, he paid half the premium for his employees' health coverage. But by the end of 1988, the premiums had become so high he could no longer afford to pay his share. "It's one of those things that could break you," he says. His employees now pay the entire cost of their coverage.

Like many small employers, he changed carriers every few years, searching for the lowest premiums. Two years ago Pudiwitr, who is 55, had a heart attack, and the wife of one of his employees, Ian Sutherland (pictured in background), had cancer surgery.

When his present carrier, American Western Life, sent a renewal notice last summer, Pudiwitr's monthly premium had jumped from $272 to $543, and the premium for Sutherland doubled from $421 to $842.

Luckily, Sutherland turned 65 and became eligible for Medicare, but he still must pay $450 a month for his wife's coverage. Pudiwitr has a long way to go until Medicare pays his bills, and he doesn't know what he'll do when his premiums rise again. "It's almost to the point where I can't afford it. If it doubles again, there's no way I can pay $1000 a month for health insurance," he says. "I didn't have any idea this would happen to people."



Crisis: Locked in

Kay Nichols, a fitness counselor at a Gainesville, Fla., health club, is in the pink of health except for glaucoma, an eye disease that can cause blindness if not treated. Not long ago, her employer wanted to switch insurance carriers to take advantage of lower premiums. When the health club found another insurer, the agent told Nichols that she would not be covered, even though her glaucoma is under control.

Nichols looked into a conversion policy from her present company but found she would have to pay $6000 for six months of coverage for her family. She tried Blue Cross, but its policy would have excluded coverage for glaucoma.

When her employer learned of her plight, he decided to keep the current policy despite its higher premiums. "If the premiums get phenomenally high, they can't keep the policy just for me, and I understand that," Nichols says. At the same time, she realizes she has a problem that won't go away. "Maybe I don't want to stay with this company the rest of my life," she says. "It makes me worry."

Nichols is 38.

profit, and they can increase their odds of success by insuring good risks who are unlikely to have health problems. Competition among carriers for the healthiest risks has become cutthroat.

In large businesses with many employees, it doesn't matter if some employees have serious medical conditions. The risk they pose can easily be spread among the healthy workers. But in a small group with few employees, insurance companies cannot collect enough in premiums to pay the claims of those who are sick. So the rules for insuring workers in small businesses are more rigorous.

Insurers use a controversial scheme to insulate themselves from risk. They offer to insure employees in a small firm (usually those with fewer than 25 workers) at a "lowball" premium for at least the first year. If members of the group experience costly health problems in the second and third years, the carrier tosses the firm into a pool with other groups whose health-care costs are high and jacks up its premiums as much as 200 percent.

By placing firms into several "rate tiers," insurance companies can bid for the healthiest groups with rock-bottom premiums. But employers and their employees who have had serious health problems are stuck with their present insurance carrier; they can't move to another because no other company is likely to take them at any premium. Worse, the present carrier may decide not to renew the group's coverage, forcing employers and employees to find other insurance. And that may be impossible.

No coverage for the sick

Companies insuring small groups require employees and their dependents to meet tough health requirements, just as they do for individuals buying policies on their own. No carrier wants to insure employees and dependents who have had heart attacks or cancer. They will either exclude them from the policy or decline to insure the group altogether. Sometimes a single employee with a serious disease is enough to earn a rejection slip for the whole group.

Increasingly, insurance companies are turning down people with far less serious health conditions than cancer or heart disease, excluding everyone except those in perfect or near-perfect health. "We don't want to buy a claim," is how one company official puts it.

Many people who become ill while they are working may find themselves without insurance when they leave the security of their employer's policy. Indeed, many are held hostage to their current job just to keep their insurance.

Susan Turner (not her real name) knows how vulnerable a person can be. Turner, who asked us not to identify her, earns $19,000 as a secretary for a small accounting firm in Texas. Her daughter, who's now 20, was born with an immune deficiency disease that makes her susceptible to infections. Every four to five weeks, she needs a lifesaving infusion of antibodies that costs about $2400.

The firm's Blue Cross policy has been paying most of the bills. But as a result of those expenses, the cost of coverage has risen sharply—both for the firm, which pays the premiums for its employees, and for the employees, who must pay the premiums for their dependents.

"When I was given my review, I was told I might look around to see if I can find another job," Turner says. "They intimated that if I did leave, it could lower the cost of their insurance."

If Turner leaves her job, it's unlikely her daughter will ever again have coverage. And there's no way she can pay for the monthly infusions herself. "Without the medicine, my daughter dies. That's the black and white of the situation," Turner says.

WHICH POLICIES ARE BEST?

If you lose your health-insurance coverage for any reason, you can remain uninsured and take your chances, or you can venture into the marketplace for an individual policy. Be forewarned: You won't find a buyer's market. And even if you're in good health, you may have few options.

This report will help guide you through the process. We evaluated 71 policies from 40 insurance companies and Blue Cross and Blue Shield organizations. We rate those policies and list their features beginning on page 14. Before plunking down $2000 or $3000 for coverage, however, you'll need to know a little about how these policies work.

Declining coverage: The proportion of employees in group health plans at large- and medium-sized firms dropped 14 percent from 1986 to 1988.

Types of policies

There are three basic kinds of health-insurance coverage:

□**Major-medical policies.** These are the most comprehensive, covering both hospital stays and physicians' services in and out of the hospital.

□**Hospital-surgical policies.** These cover hospital services and surgical procedures only.

□**Hospital-indemnity and dread-disease policies.** These policies are vastly inferior to the other two types and offer very limited benefits. They are discussed in the box on page 8.

What's covered?

Major-medical policies typically pay for most hospital services, including room and board; operating and recovery rooms; nursing care; and treatment in intensive-care units, emergency rooms, and outpatient facilities. They also pick up the tab for lab tests, X-rays, anesthesia, medical supplies, ambulance services, and physicians' office visits. Most pay for prescription drugs and cover confinements in skilled-nursing facilities, if necessary, following a hospital stay.

Some policies, however, don't pay for assistant surgeons or for stand-by surgeons. Others won't cover emergency treatment unless the policyholder is admitted directly to the hospital. (That's to discourage the use of emergency rooms for routine treatment.) Still others limit the number of times they'll pay for doctors' visits in the hospital. Even a comprehensive policy may pay for only one visit each day.

Hospital-surgical policies cover hospital room and board, often for a specified number of days; treatment in intensive-care and outpatient facilities; medical supplies; surgeon's fees; diagnostic tests relating to an operation; some radiation and chemotherapy; and sometimes second opinions. But they cover almost no expenses incurred outside a hospital. They won't pay for a doctor's office visit to check on a persistent cough, or to have your child's cast removed, or for any medical condition that does not require hospitalization. Most don't cover prescription drugs that you may need outside a hospital.

Generally, both major-medical and hospital-surgical policies pay for 30 days of inpatient treatment for mental illness and substance abuse. Some major-medical policies cover outpatient treatment as well. If they do, insurers limit the number of visits per year or even the dollar amount of their payments.

Maternity benefits

All the major-medical and hospital-surgical policies in our study pay for expenses arising from pregnancy complications. But with the exception of some Blue Cross and Blue Shield plans, they usually don't cover routine prenatal care or routine deliveries.

If you want coverage for that, you'll have to buy a separate rider, and at some companies, you'll need to decide on the rider the day you take out the policy. Some carriers won't let you buy the rider later (on the grounds that you'll probably use the coverage, and they'll be stuck with a claim). Many major-medical and hospital-surgical policies don't offer riders for routine maternity care, period.

Riders will pay up to a maximum benefit that policyholders select, usually $500, $1000, $2000, or $2500. Rarely do they cover the full cost of a normal delivery, which averaged $4334 in 1989.

Another drawback is that companies don't pay the full benefit during the first two years the policy is in force. A policyholder who becomes pregnant may receive only 50 or 60 percent of the benefit in the first year and 75 percent in the second year. Not until the third year are full benefits paid.

Annual premiums for pregnancy riders ranged from $316 at Golden Rule for a $1000 benefit to $2640 at Prudential for a benefit that would cover the hospital stay but only $1050 of an obstetrician's fee. (An obstetrician's services for prenatal care and delivery can cost as much as $4500 in some areas.)

What's not covered

Both major-medical and hospital-surgical policies cover only medically necessary care. Don't count on them to pay for routine physicals or other preventive services. (Some of them, however, cover Pap smears, mammograms, and well-child care.) Nor do companies pay for cosmetic surgery, fertility treatment, dental care, hearing aids, surgical treatment of obesity, treatment for self-inflicted injuries, or procedures that are considered experimental.

How policies pay

Insurance companies compute the amount of your reimbursement check according to their own complex formulas. The amount may be higher or lower depending on the following:

Eligible expenses. When you submit a bill for a service covered by a major-medical policy, the insurer compares it with the amount it normally pays for that service. If the charge is lower than what the company determines is "usual," "customary," "reasonable," or "common," then the entire bill is eligible for reimbursement. If it's greater, the carrier will consider only a portion of it.

What portion the company considers differs among insurers. Each company sets its reimbursement level based on physicians' charges for services and procedures in your area. One company might choose to reimburse policyholders based on the charge that represents the 90th percentile for a given procedure or service. Another might choose the 75th percentile. (For hospital services, companies pay either the

hospital's posted charge, the hospital's cost, or a negotiated fee.)

Obviously, the higher the reimbursement standard, the more you'll receive. Unfortunately, policies don't spell that out, and some insurance companies were reluctant to explain their reimbursement standards to us.

Some hospital-surgical policies work differently, paying up to a maximum amount for each covered procedure or service listed in the policy. There's usually a fee schedule for hospital room and board, one for surgeon's fees, another for outpatient services, and a maximum amount the policy will pay for all other hospital services. This is the equivalent of a hospital-surgical policy's eligible charge.

Amounts paid by hospital-surgical policies usually fall far short of the actual charges. For example, Metropolitan's policy will pay a surgeon who performs an appendectomy as little as $260 or as much as $480, depending on the schedule the policyholder picks; in 1989, the average surgeon's charge was $846 for an appendectomy. The policy pays as little as $390 or as much as $720 for a hysterectomy; but a hysterectomy cost an average of $1737 in 1989.

Coinsurance. Once the insurer determines how much of your bill it will consider, it still pays only a portion. You pay the rest. That's called "coinsurance."

Most major-medical policies pay 80 percent of eligible expenses, leaving policyholders to pay the remaining 20 percent plus that part of the cost not covered at all.

Suppose a physician charges $3000 for an angioplasty (a cardiac procedure), but the carrier considers only $2610 as an eligible expense. If the insurer pays 80 percent, the policyholder will receive $2088 (80 percent of $2610). He or she will then have to pay the remaining 20 percent, or $522, plus the $390 that's not eligible for reimbursement.

With some policies from Blue Cross and Blue Shield, a policyholder who used a "participating physician" would pay less. Participating physicians agree not to bill patients in excess of what Blue Cross and Blue Shield pays. This can be a significant advantage. Plans with this feature are noted in the Ratings.

Some major-medical policies require policyholders to pay less than the usual 20 percent coinsurance. For example, American Republic's *UltraCare* policy requires no coinsurance at all. Policies from Bankers Life and Casualty and its affiliated companies require none if policyholders select a deductible of at least $5000—that is, if the policy-

Pay by the Day? By the Disease?

THE WORST TYPES OF INSURANCE

The worst buys in health insurance are hospital-indemnity policies and dread-disease policies. Hospital-indemnity policies pay a fixed amount each day you're in the hospital. Dread-disease policies pay benefits only if you contract cancer or some other specified illness.

Such policies are a profitable staple for many well-known insurance companies and for the American Association of Retired Persons (AARP). They're sold to unsophisticated buyers through enticing but sometimes misleading advertising.

"Cash benefits of $2250 a month, $525 a week, $75 a day . . . You cannot be turned down . . . No salesman will call . . ." reads a flyer for a hospital-indemnity policy from Physicians Mutual. "Use these cash benefits any way you choose . . . Get extra benefits when you may need them most," promises an ad for a policy sold by the AARP.

The deal is simple and understandable. You get a fixed dollar amount for each day you spend in the hospital. No complicated deductibles or coinsurance. Trouble is, the fixed benefit is skimpy to start with and grows less valuable with each passing year.

At Physicians Mutual, a person can choose a daily benefit of $30, $50, or $75. AARP's top benefit is $75 for those age 50 to 64 and $45 for those 65 and older. But with the cost of a day in the hospital averaging around $800, even the most generous hospital-indemnity plans will barely dent your bill. Furthermore, to collect the high benefits touted by some of the ads, you'll need to be hospitalized as long as a month—an unlikely prospect, since the average stay is only about seven days. Finally, the benefit does not change. In time, inflation in hospital and medical costs inevitably shrinks its value.

Dread-disease policies offer similarly inadequate benefits. We measured two cancer policies against a $19,774 claim for colon-cancer surgery and follow-up chemotherapy that we also used to rate the policies in our survey. A policy from American Family Life, a large seller of this type of insurance, would pay a maximum of $4100; a policy from American Fidelity Assurance would cover as much as $6210—but only if the policyholder had purchased some optional coverage. (These policies may also pay an additional benefit based on the number of months you own the policy before you contract cancer.)

Companies also sell riders to cover such dread diseases as smallpox, polio, rabies, diphtheria, and typhoid fever. We don't know why anyone would buy them, since these diseases are now extremely rare.

Compared to other health coverages, these types of insurance are cheap. For the top daily benefit from Physicians Mutual, a 45-year-old man or woman would pay about $233 a year. A family would pay $540.

Insurers usually issue hospital-indemnity policies to anyone, whether or not they are in good health. But carriers often require a waiting period before covering policyholders for preexisting health conditions.

Most companies selling cancer insurance will not, however, issue policies to people who already have cancer. Nor do they usually pay benefits to anyone who is diagnosed as having the disease before the policy has been in force for 30 days.

These policies are no substitute for comprehensive health coverage. The price is low, but so are the benefits. With a dread-disease policy, you're also gambling that you'll contract one of the covered diseases. If you don't, the policy won't cover you.

Companies often market these policies as a supplement to other insurance. But we don't recommend them even for that. The $300, $400, or $500 you'd spend for inferior coverage may equal the difference in premium between a skimpy hospital-surgical policy and a more comprehensive major-medical policy. Or it may cover the cost of taking a lower deductible on a good major-medical policy.

holder pays the first $5000 of covered expenses.

Other companies require policyholders to pay more. You might find policies with a 70/30 percent or even a 50/50 percent cost-sharing arrangement, especially if you don't use doctors and hospitals specified by the insurer.

Coinsurance maximums. Most policies specify a maximum dollar amount of coinsurance, typically $1000 (but it can be as much as $2500 or $5000), that policyholders must pay annually. After they've reached that amount, the carrier pays 100 percent of all additional, eligible medical expenses.

A few policies tie coinsurance maximums to the size of the deductible you select. The higher the deductible, the lower the maximum.

Several policies give a break to families. Usually two members must each pay the maximum coinsurance amount. The company will then pay 100 percent of all eligible expenses for other members who have not reached their maximums.

Truth will out: When you fill out an application for health insurance, be honest about your medical condition. If you don't reveal all your health problems and the company finds out about them when you file a claim, it could rescind your policy and leave you without coverage when you need it most.

Lifetime maximums. Most major-medical and hospital-surgical policies cap the benefits they'll pay over a lifetime at $1-million or sometimes $2-million. A few have no cap, and others have a separate lifetime maximum for each illness or injury.

A company will sometimes give new lifetime benefits to policyholders who have generated enough claims to reach their lifetime cap. This is an important feature if the cap is low.

Deductibles. Most companies require policyholders to satisfy deductibles each year before benefits are paid. (Some hospital-surgical policies have no deductibles.) Deductibles can be as low as $100 or as high as $20,000. That means a policyholder must pay the first $100 (or $20,000) of expenses before the company pays any benefits. Obviously, a $20,000 deductible buys only catastrophic protection.

Sometimes a policy links the deductible to an illness or health condition; you would have to satisfy the deductible with each new illness. If the deductible is large and you have several different illnesses, you may never collect any benefits.

Some companies no longer offer low deductibles. "If somebody can afford to buy our product, he can afford a $1000 deductible," says John Hartnedy, the chief actuary at Golden Rule. "You don't want first-dollar coverage. It may cost $80 to take care of a $50 bill."

As with most insurance, the higher the deductible, the lower the premium. A 45-year-old man in Chicago who chooses a $500 deductible for Benefit Trust Life's *Tele-Med* policy would pay an annual premium of $1443. If he selected a $2500 deductible, he would pay only $839.

Sometimes, for a small, extra premium, companies will waive the deductible or a portion of it if you are injured in an accident.

Can you renew?

Few companies will guarantee to renew your coverage. Of those in our study, only American Republic, Benefit Trust Life, and Metropolitan sell "guaranteed renewable" policies. The company can raise the premium, but it must continue your coverage.

Most policies, however, are now "conditionally renewable." The company can refuse to renew your policy only if it also refuses to renew all other similar policies in your state. You have some protection because the company can't single you out for cancellation. But you can still lose your coverage.

Some insurance companies use conditionally renewable policies as a lever to force insurance regulators to grant the rate increases those companies want. Certified Life, First National Life, Golden Rule, and Washington National told us they had canceled policies. In some cases, they offered policyholders alternative coverage.

A few policies are "optionally renewable." A company can opt not to renew your insurance whether or not it renews coverage for others who have the same policy. Prudential, State Farm, and Blue Cross and Blue Shield plans in Illinois, Kansas, Ohio, and Oklahoma have optionally renewable policies. (Prudential and Blue Cross and Blue Shield of Oklahoma at least say they won't cancel your policy if your health has deteriorated.)

Many companies also give themselves the option of not renewing if they find you have another policy that is similar.

Are you insurable?

People who have medical problems, however minor, are second-class citizens in the world of health insurance.

Virtually no commercial carriers and only a handful of Blue Cross and Blue Shield plans will sell policies to anyone who has had heart disease, internal cancer, diabetes, strokes, adrenal disorders, epilepsy, or ulcerative colitis. Treatment for alcohol and substance abuse, depression, or even visits to a marriage counselor can also mean a rejection.

If you have less serious conditions, you may get coverage, but on unfavorable terms.

Conditions that usually affect one part of the body are candidates for "exclusion riders." That is, companies will offer a policy, but exclude coverage for those conditions or that body part, either for a short period or for as long as the policy is in force. If you have had a recent knee operation, glaucoma, migraine headaches, varicose veins, arthritis, a cesarean delivery, or if your child suffers from chronic ear infections, your policy will probably carry an exclusion rider. "Any condition that would produce an immediate claim would be ridered out," says Frank Fugiel, a vice president at Washington National.

If you have a medical condition that affects your general health—for example, you're significantly overweight or have mild high blood pressure—you may get coverage, but at a price 15 to 100 percent higher than the standard premium.

Companies in our survey told us that between one-quarter and one-half of all their policies carry exclusion riders, higher-than-standard premiums, or both.

Insurers, however, are not restrictive in identical ways. Washington National will exclude coverage for your eyes if you had a cataract operation a year ago. Prudential will not. If you suffered from migraine headaches in the past but have had no treatment for the last two years, Central States Health and Life will cover future treatment for such headaches; Time will issue a policy but exclude coverage for migraines.

If a company rejects you, that fact will be recorded at the Medical Information Bureau in Boston, an industry clearinghouse. The next time you apply for coverage, the new carrier may check your file at the bureau. If it finds you've been turned down, that rejection could trigger further scrutiny of your health.

Even if your health is perfect, you still may be a less-than-perfect risk. In their quest for applicants who are

unlikely to file claims, insurance companies blackball people in certain occupations. Some companies have long lists of jobs that are unacceptable, either for an individual policy or for a policy sold to employees in small firms. Chances are the insurance company won't cover you if it considers your work hazardous or if people in your profession are more likely to file claims or switch jobs frequently.

Better off at the Blues?

Historically, most Blue Cross and Blue Shield plans took all comers for individual health insurance, offering "open-enrollment" policies that anyone could buy. Even if your health was bad, you could count on getting a policy from the Blues.

In mid-1990 only 22 of the 74 Blue Cross and Blue Shield plans in the U.S. still make policies available to everyone. But their "open-enrollment" policies may require policyholders to pay a larger portion of their expenses than policies offered to those in good health. For example, the open-enrollment major-medical plan sold by Empire Blue Cross Blue Shield in New York requires 20 percent coinsurance for all services. By contrast, its high-rated *Tradition Plus Wraparound* policy, sold only to those with no medical problems, requires no coinsurance on hospital services and also offers a much lower deductible.

Most Blue Cross and Blue Shield organizations now "underwrite." That is, they evaluate an applicant's health much the same way their commercial competitors do. They decline people with cancer and heart disease and sometimes issue policies with exclusion riders and higher premiums.

It's hard to say whether you'll have an easier time buying coverage from the Blues than from commercial insurers. Most of the Blue Cross plans we contacted refused to respond to our survey. Through other sources, we obtained the plans sold by uncooperative Blues and evaluated them along with the others.

Blue Cross plans that do not exclude health conditions or charge higher premiums for them may simply refuse to sell you a policy. On the other hand, a Blue Cross plan might be more lenient than a commercial insurer. Empire Blue Cross Blue Shield does not require blood tests to detect AIDS. Kentucky Blue Cross and Blue Shield insures women with fibrocystic breast disease. Commercial carriers often require blood tests and almost always exclude coverage for fibrocystic breasts.

Preexisting conditions

If you get a policy from Blue Cross and Blue Shield or a commercial insurer, you still may have to wait a year or two to be covered for medical conditions you already have.

Most policies say that a preexisting condition is one for which a policyholder has received treatment or for which a reasonably prudent person *should have sought* treatment during the previous two years. Some policies have shorter or longer "look-back" periods. Those are noted in the Ratings. *Continued*

The Last Resort

HIGH-RISK POOLS

If you can't buy health insurance and you live in one of 23 states listed below, your insurer of last resort is a high-risk pool created for the people insurance carriers don't want. Similar to the high-risk plans for drivers who've been in accidents, health-insurance pools originated in the 1970s as the industry's alternative to national health insurance. But only in the last few years have states begun to get serious about them.

To obtain coverage, you usually must be a state resident for at least six months (a year in some states), and must have received a rejection notice from at least one carrier (Montana and Florida require two rejections).

If a carrier will insure you only at a premium exceeding the price of coverage from the pool, or if the insurance you're offered carries exclusion riders, you will also be eligible for a pool policy in most states.

The rules differ from state to state. Illinois, Iowa, Minnesota, and Nebraska, for example, allow people infected with the HIV virus to obtain a pool policy; South Carolina does not. In some states you can't get pool coverage if you're eligible for a conversion policy when you leave an employer group, even though the pool policy may be better than the conversion option.

Florida, Illinois, Iowa, Minnesota, North Dakota, Tennessee, Washington, and Wisconsin make Medicare-supplement policies available through their pools. That's a boon to the disabled under age 65 who rely on Medicare but can't find insurance to fill Medicare's gaps.

Pool coverage is similar to that offered by a major-medical policy, although benefits for mental and nervous disorders, organ transplants, and pregnancy may be less comprehensive. You may, however, pay more out-of-pocket than you would with a major-medical policy. Some plans require a high deductible, greater coinsurance, and relatively low lifetime-benefit maximums—$500,000 or even $250,000.

Premiums are no bargain, which is not surprising since policyholders in the pool will almost certainly file claims. For example, a policy with a $500 deductible from the Illinois pool will cost a 45-year-old man living in Chicago $3844 a year. That's twice as much as he'd pay for the most expensive individual policy in our study available to Chicagoans.

Long waiting lists

Pool policies provide decent coverage, but they are available only to a fraction of those who need them. CU surveyed the pools in the spring of 1990 and found that they now cover only 55,500 people nationwide. Pools in Illinois, Maine, and Oregon currently limit the number they can insure. The Illinois pool can issue only 4500 policies. The wait to buy into the Illinois pool is now at least a year.

It's hard to see how the pools can meet even the existing need. They operate at a loss, despite the high premiums. In most states, losses are covered by assessments against all health-insurance carriers doing business in the state. In return, some states relieve insurers from part of their obligation to pay taxes on the premiums they collect.

But the insurance industry is pressing the states to pick up more of the bill from the public purse. "We're not in the business of giving away insurance at a loss to these people," says Carl Schramm, president of the Health Insurance Association of America.

The 23 states with high-risk pools are: California, Colorado, Connecticut, Florida, Georgia, Illinois, Indiana, Iowa, Maine, Minnesota, Montana, Louisiana, Nebraska, New Mexico, North Dakota, Oregon, South Carolina, Tennessee, Texas, Utah, Washington, Wisconsin, and Wyoming. (The pools in California, Colorado, Georgia, Louisiana, Texas, Utah, and Wyoming are not fully operational.) Your state insurance department can tell you how to contact your state's pool.

To encourage applicants to reveal all their medical conditions, some companies waive their usual waiting periods *if* you have disclosed all your health problems (providing the company is willing to accept you and not exclude coverage for those conditions).

What policies cost

The premiums you pay are based on your age, your sex, and where you live.

At Bankers Life and Casualty, a healthy 45-year-old man living in Chicago would pay $1245 a year; a 45-year-old woman, $1625; a 55-year-old man, $1748; and a 55-year-old woman, $1852.

The premium for a 40-year-old man, his 35-year-old wife, and two children would come to $3382.

A few Blue Cross plans still use "community rates," charging everyone the same premium regardless of their age or where they live. Other things being equal, older people are usually better off at a company using community rates. A 45-year-old man and a 60-year-old man living in Philadelphia would pay the same $2192 premium at Independence Blue Cross and Pennsylvania Blue Shield. But at Time, a company not using community rates, the 45-year-old man would pay only $1580; the 60-year-old, $3375.

With most policies, premiums increase as you get older. If you buy a policy at age 40, expect the premium to increase when you turn 45.

In addition to age-related increases, the rising cost of medical care also pushes up premiums every year or two. The premiums for policies in our study increased an average of 11 percent a year over the past five years. But premiums for some policies rose as much as 40 or 50 percent in a single year.

The wrong job: Occupations some insurance companies consider unacceptable for health coverage:

Tree trimmers
Explosives handlers
House painters
Window cleaners
Heavy-equipment operators
Rodeo performers
Police officers
Doormen
Models
Freelance artists
Waiters
Masseurs
Hospital aides
Maids
Musicians
Bartenders
Fry cooks
Janitors
Street cleaners
Doctors
Lawyers
Pro athletes
Fishermen
Railroad workers
Test drivers
Car-wash workers
Dancers
Beauticians
Movers
Zoo attendants

Pricing tricks

As a sales gimmick, some companies use a pricing scheme that gives policyholders a deceptively low premium the first year and very high premiums in later years.

When a company that uses so-called select and ultimate rates accepts you for coverage, it knows you're in good health and charges a low (select) premium to reflect the fact that you're not likely to file claims in the immediate future. But as the years go on, and as you make claims, the company will jack up the premium to the highest (ultimate) level.

Companies that don't use select and ultimate rates spread the anticipated costs of your claims over all the years you own the policy, so your premiums will be more stable. If you buy from a company using select and ultimate rates, you may face premium increases that far exceed what you can afford.

State insurance regulators don't require insurers to disclose whether they use select and ultimate rates, so it's often hard to know. It's a good idea, though, to ask whether a company you're considering uses such rates and to avoid their policies, especially if you plan to keep the coverage for several years. One carrier, Aid Association for Lutherans, gives buyers in some states a choice between policies with select and ultimate rates and those without, and clearly points out the differences in its sales material. (Our Ratings include Aid Association's policy without select and ultimate rates.)

Managed care and PPOs

Until recently, insurance companies seldom questioned physicians' fees. But to hold down their own costs, companies have now inserted a variety of "managed care" requirements into their policies.

As a result, you may have to ask the insurance company for prior approval for any elective surgery. You may have to use an outpatient facility for such procedures as arthroscopic surgery, dilation and curettage, and cataract removal. You may be required to seek second opinions before surgery. If you don't follow the rules, the company may reduce your benefit or increase the coinsurance and deductible you'll have to pay.

Some Blue Cross and Blue Shield plans offer Preferred Provider Organizations (PPOs). Those are groups of doctors who have agreed to discount their fees. If you sign up for a PPO and use a non-PPO doctor, you may have to pay as much as 40 or 50 percent of the doctor's bill yourself and also suffer other penalties.

How we rated the policies

Most Blue Cross and Blue Shield organizations and a handful of commercial carriers sell individual health coverage. Twenty of the 29 Blue Cross and Blue Shield plans we approached for information refused to cooperate with our study, forcing us to turn to state regulators to obtain necessary information on their policies, premiums, and rate histories. (Surprisingly, some regulators made it difficult to obtain the information, even though data filed with public agencies is usually available to the public.) The Blue plans that refused to answer our questionnaire are noted in the Ratings with an asterisk.

A few other insurers also declined to participate. Celtic Life, a company waging a public campaign to educate people about shopping for health insurance, refused to shed any light on its policies or selling practices. A newcomer to health insurance, A.L. Williams, a company better known for its life-insurance policies, also declined to participate. A third company, World Insurance, claimed that if it won a favorable rating from CONSUMER REPORTS, it would not have the capacity to handle all the applications.

We rated the major-medical and hospital-surgical policies by measuring the coverage and cost-sharing features of each against actual claims, ranging from minor to catastrophic, filed by 25,000 employees. The average annual claims for a single person in the reference group totaled $1387; for families, it was $3175.

A policy that covers everything would pay 100 percent of those amounts. Of course, health-insurance policies are not designed to cover 100 percent of claims. But the best policies pay the most.

The best policy we found, a major-medical plan sold by Blue Cross and Blue Shield of Minnesota, would pay $1230 (or 89 percent) for singles and $2810 (or 89 percent) for families if you used physicians in the plan's preferred-provider organization. The worst, a hospital-surgical policy from Pyramid Life, would have paid only $490 (or 35 percent) for singles and $950 (or 30 percent) for families.

The Ratings show what percentage of the average annual claims each policy would pay after accounting for deductibles, coinsurance, coinsurance maximums, and other cost-sharing features spelled out in the contract.

Since most people want a policy that provides coverage for catastrophic expenses, we also measured how well each would pay for two major illnesses. One was a $19,774 claim for colon-cancer sur-

gery and follow-up chemotherapy. The other was a $49,767 claim for care of a serious heart attack, including an angioplasty procedure (see box on page 13).

A good policy is useless if the company can cancel it, or if rate increases are so steep you can't pay the premiums. Therefore, we gave weight to each policy's renewability features and rate-increase history. A policy scored highest in these factors if it was guaranteed renewable and if the company's rate increases over a five-year period were less than the medical consumer price index.

We also looked at a policy's lifetime benefit maximum, its preexisting conditions clause, and coverage provided by the maternity rider.

We could not obtain rate-increase histories or certain other information for noncooperative Blue Cross and Blue Shield plans or for new policies. Where we lacked information that might affect a plan's score,

Blue Cross and Blue Shield

ABANDONING THE MISSION

Sick people cannot buy a policy from Blue Cross and Blue Shield of Kentucky. The plan evaluates an applicant's health and rejects those with such afflictions as cancer, heart disease, emphysema, and AIDS.

Competition from commercial carriers has forced the plan to turn sick people away in order to keep its premiums affordable and attract new customers. At one time, Kentucky's Blue Cross and Blue Shield plan sold as much as 90 percent of all health insurance in the state. In 1990 it sells just 30 percent.

The Kentucky plan, typical of many Blue Cross and Blue Shield organizations in 1990, is a far cry from what such plans used to be. Founded by organized medicine in the 1930s, Blue Cross (and later Blue Shield) had two missions. The first was to make sure hospitals and doctors got paid. The second was to provide health insurance for the greatest number of people.

For years, the Blues had a virtual insurance monopoly. In some places, they were so powerful that they were able to negotiate large discounts from hospitals and use the savings to carry out their mission of community service. For example, Blue Cross plans subsidized such money-losers as individual health policies for the sick and Medicare-supplement coverage for the elderly.

As nonprofit organizations, the Blues had certain privileges. They paid no Federal income taxes and, in many states, no taxes on the premiums they collected.

"Community rating" was once the Blues' trademark. Everyone in the community—large employer groups, small employer groups, and individuals buying policies on their own—were in the same risk pool. They paid the same rates regardless of their age and sex, where they lived, or how sick they were.

That all began to change in the 1960s. Commercial insurers started skimming the best risks from the Blue Cross pool by offering lower premiums than the Blues charged. As large groups and then small ones took out cheaper policies with commercial carriers, the Blues increasingly found themselves covering people with health problems the commercial carriers didn't want. As healthy people deserted the pool, the Blues had little choice but to raise premiums higher and higher to cover the claims made by the sick people who remained.

In many areas, the plans also saw their hospital discounts whittled away. Some states now mandate smaller discounts and allow all insurers to receive them.

Blue Cross and Blue Shield of Kentucky, for example, receives only a 7 percent discount from the hospitals. And it does not subsidize individual health coverage (other than conversion policies) out of the profits from other lines of business. At the suggestion of insurance regulators, it abandoned community rating a few years ago in favor of the kind of pricing used by its commercial competitors.

Most Blue Cross and Blue Shield plans now resemble Kentucky's. Many have become mutual insurance companies. They've lost their tax exemption from the Federal government, and they no longer try to provide coverage for everyone. Less than one-third still take all comers for health insurance. Of the 37 state regulators responding to a CU survey, only nine consider their local Blue Cross and Blue Shield plan an insurer of last resort.

"We think the Blues in our state do a pretty good job. But everyone here dislikes them, from their subscribers to the legislators," says one state insurance regulator who asked not to be identified. "They are some of the most defensive people you can imagine. Everything we ask for is a fight."

We know what he means. We asked 29 Blue plans to send us information about their policies. Only nine would do so, forcing us to seek information from state regulators, who sometimes couldn't or wouldn't help us. The California Insurance Department told us it had no rates on file for Blue Cross of California. When we asked the plan for a history of its rate increases, an official told us that information was "proprietary." When we asked the Washington Insurance Department to give us rate-increase data for the Washington and Alaska plan, the department said it could not oblige because Blue Cross had a right in that state to keep such information a secret.

"As their risk pool gets creamed, there's mission schizophrenia at the Blues," says Susan Sherry, an official at Families USA, a health-advocacy group. "It's the classic example of competition, and consumers are the real losers."

Some Blue Cross and Blue Shield plans, mostly in the Northeast, still cling to the old mission. But even for them, holding on is increasingly difficult.

In New York, a person no matter how sick can always get health insurance from Empire Blue Cross Blue Shield. It won't be the top-of-the-line policy, but it will provide some coverage.

Empire, which still uses community rates, can sell insurance even to people with terminal illnesses because their policies are heavily subsidized from premiums paid by large employer groups and from the savings obtained by negotiating a 13 percent discount with New York hospitals.

Even so, Empire officials say that the discount is not large enough, and that over the last few years some 100,000 people have left the pool, either going with commercial carriers or doing without coverage altogether. The plan has had to increase premiums on all its policies 40 to 50 percent to cover the claims of the sick people who remain.

"Our goal is to stay with the mission," says Eric Schlesinger, Empire's chief marketing officer. "But in the end, we will have a community price so high that no one will pay it, and the number of uninsured will skyrocket."

we assigned values representing the average for all plans in our survey. This lack of actual information for a plan is denoted by a dash in the Ratings. The plans are listed in order of an overall quality index that takes into account all the rating factors.

Recommendations

Naturally, you want a policy that will pay as many of your bills as possible, so coverage should be your first concern.

Unfortunately, there are few policies for any one individual to choose from. Your options boil down to a policy from one of the few remaining commercial carriers selling this insurance or one from your local Blue Cross and Blue Shield plan.

The best coverage is provided by a good major-medical plan. The plans listed high in the Ratings require policyholders to pay very few of their medical expenses.

A number of Blue plans—in Minnesota, New Jersey, New York, and Pennsylvania—ranked high. People in those states should certainly consider them. As the Ratings show, however, Blue Cross and Blue Shield organizations in other states offer mediocre or poor policies.

Fortunately, some good commercial plans are widely available. Look first at the high-rated policies offered by American Republic and Benefit Trust Life.

Maternity benefits from some of the Blues were better than those offered by most commercial carriers. Many Blue plans treat pregnancy as an illness and pay normal benefits, which will cover most of the cost of having a baby. But some offer maternity benefits only on family policies. Presumably a single woman who became pregnant would not have coverage.

Some Blue Cross and Blue Shield plans offer a choice of a regular insurance policy and a PPO. You might consider a PPO if you're willing to use its doctors rather than your own. The PPOs offered by Blue Cross and Blue Shield in Arizona, Illinois, Minnesota, and Washington and by Blue Shield of California ranked higher in our Ratings than those organizations' traditional insurance plans because they require their subscribers to pay less coinsurance.

Policies from First National and Washington National provide good benefits for catastrophic expenses but fall short in other important areas, such as policy cancellations or rate increases.

Note that the policy from the largest seller of individual major-medical insurance, Golden Rule, ranks near the bottom. The policy provides only average coverage. And the company has a history of large rate increases and canceled policies.

Once you have considered a policy's coverage and other dimensions, look at the premium. If two policies are comparable, pick the one with the lowest premium.

Hospital-surgical plans cost less than major-medical policies, but they generally provide much less coverage. At Bankers Life and Casualty, a 45-year-old man living in Chicago would pay $806 a year for a hospital-surgical plan, compared with $1245 for the company's major-medical policy. But as you can see from the column labeled "Payout," the coverage offered by these policies is, for the most part, decidedly inferior to that provided by major-medical policies.

The highest room-and-board coverage offered by the hospital-surgical policy from Blue Cross and Blue Shield of Maine, for example, is $276. Some of the state's hospitals have room-and-board charges that exceed $400.

Hospital-surgical plans provide fewer benefits, and those benefits may not increase with the cost of medical care. Unless the carrier lets you upgrade, the benefits you buy today may be inadequate if you need hospital care several years from now.

If you can't swing the premiums for a high-rated major-medical policy, consider reducing the premium with a higher deductible, then budget to cover small medical expenses yourself.

If you're not in perfect health, it's hard to buy coverage at any price. It may nevertheless be worthwhile to shop several carriers to see if they'll issue coverage with exclusion riders.

If you live in Alabama, Hawaii, Maryland, Michigan, New Hampshire, New Jersey, New York, North Carolina, Pennsylvania, Rhode Island, Vermont, Virginia, or the District of Columbia, you will be able to buy an "open-enrollment" policy from Blue Cross and Blue Shield at least sometime during the year.

In Maine, the Blue Cross and Blue Shield organization accepts anyone for coverage, but will add exclusion riders for three years on policies for people with various health conditions.

If you live in one of 23 states with a high-risk pool, you may be able to purchase coverage from the pool.

There's no insurer of last resort for people living in the other 15 states. Short of getting a job with a large business or marrying someone who works for one, people who are unacceptable to insurance companies are out of luck. They have no choice under the current system but to join the growing ranks of the uninsured.

Ratings begin on page 14

Catastrophic Claims

PERCENTAGE GAMES

As part of our evaluation of health-insurance policies for the accompanying report, we measured how much each policy would help defray the actual bills run up by two patients in apparent good health who were suddenly stricken with a life-threatening illness—colon cancer and heart attack.

The case of colon cancer cost a total of $19,774, including $13,471 in hospital bills and $3665 for surgery.

The best plan we found, from Blue Cross and Blue Shield of Minnesota, would have paid about 92 percent of the $19,774 if the policyholder used only "preferred provider" doctors. (If the policyholder went to other physicians, the plan would pay up to 88 percent.) The highest-rated policy from a commercial carrier, American Republic's *UltraCare* with no coinsurance, would have paid 97 percent. A less generous major-medical plan, from Washington National, would have paid 87 percent of the claim. Least helpful was a hospital-surgical policy from Pyramid Life. It would have paid only 49 percent of the bill, leaving the patient about $10,000 in debt.

The treatment for the heart-attack patient came to $49,767. It included an angioplasty (a procedure to open blocked arteries) that cost $8730 in surgical fees, and a 21-day hospital stay that piled up bills of $34,107.

In this case, the Blue Cross and Blue Shield of Minnesota plan would have paid about 97 percent of the $49,767 claim if the policyholder used all "preferred provider" doctors and up to 95 percent if the policyholder did not. American Republic's *UltraCare* policy with no coinsurance would have paid 97 percent. The major-medical plan from Washington National would have paid 90 percent of the claim. And Pyramid Life's marginal hospital-surgical policy would have paid only 44 percent, leaving the patient to recover from a $28,000 debt as well as the heart attack.

RATINGS

Health-insurance policies

Listed by types. Within types, listed in order of estimated overall quality, based on policies for a single person. (Family policies closely tracked single policies in overall quality.) Differences of less than 5 points were judged insignificant. Companies marked with an asterisk did not respond to our survey. Dashes indicate we could not obtain information; in those cases we assigned values representing the average for all policies.

1 Annual premiums. These are annual premiums for 45-year-old **men** and **women** living in Chicago. For a company not selling there, the premium is for the company's major operating territory. **Family** premiums assume a 40-year-old husband, a 35-year-old wife, and two children. Premiums are given for policies with $500 deductibles. If the company does not offer a $500 deductible, we show the premium for the closest deductible to $500; footnotes (on pages 16-17) state the deductible on which the price is based. Premiums for **maternity rider** show the cost of adding coverage for routine pregnancies.

2 Quality index. A summary of how the policy performed for a **single** person.

3 Payout. The percentage the policy paid for a **single** person and for a **family** on an average mix of claims filed by 25,000 policyholders. We used a $1000 coinsurance maximum for each policy. If the policy did not offer this amount, we used its maximum that was closest to $1000. Most plans require 20 percent coinsurance. Exceptions are noted in the Comments.

4 Catastrophic claims. Measures how well a policy would have paid after the deductible was met on two actual claims involving catastrophic illness—one for treatment of colon cancer; the other, a serious heart attack. A policy that scored a ● paid more than 96 percent of the expenses for both claims. A policy with a ◓ paid more

		1 Annual premiums			
	Policy	Men	Women	Family	Maternity rider
Major-medical					
Blue Cross and Blue Shield of Minnesota	Aware Gold (F2844) PPO	$1493 1 2	$1962 1 2	$5100 1 2	Included
Capital Blue Cross w/Penn. Blue Shield	Major Medical	1815 3	1815 3	3923 3	Included
American Republic	UltraCare, no coinsurance	1304 4	2240 4	5012 4	$608
Blue Cross and Blue Shield of New Jersey	Medallion	1843 2 5	1843 2 5	4759 2 5	Included
Benefit Trust Life	MMI	1794 6	2096 6	4319 6	Included
Empire Blue Cross Blue Shield	Tradition Plus Wraparound (LGL 3252)	2392 7	2392 7	6126 7	Included
Independence Blue Cross w/Penn. Blue Shield	Major Medical w/Plan 100	2192 10	2192 10	5159 10	Included
Blue Cross and Blue Shield of Minnesota	Aware Care (F2239)	658 2	882 2	2226 2	Included
American Republic	UltraComp	1632 2	1953 2	4333 2	636
American Republic	UltraCare, 20% coinsurance	1596 4	1877 4	4200 4	608
Blue Cross of Washington and Alaska*	Personal Prudent Buyer, Low Option 200, Wash.	1092 2 8	1092 2 8	2376 2 8	None
Blue Cross and Blue Shield of Alabama*	ALPHA Plan	1308 2 9 10	1308 2 9 10	3432 2 9 10	72
Blue Cross and Blue Shield of Illinois*	Non-Group PPO	1543	1932	4363	261
Blue Cross and Blue Shield of Montana*	Personal Choice Plan	1851	1851	4241	Included
Blue Cross and Blue Shield of Montana*	Healthy Montanan Plan	1553	1553	3554	Included
Blue Cross and Blue Shield of New Jersey	Direct Payment Supplemental Major Medical	3167 10	3167 10	6135 10	Included
Blue Cross and Blue Shield of Indiana*	Personal Security	1293	1374	2935	1164
Blue Cross and Blue Shield of Oklahoma*	Health Check	1764 11	1764 11	3780 11	Included
Blue Cross and Blue Shield of Maryland*	Personal Comp	1001	1001	2604	Included
Control States Health & Life	Individual Major Medical (569-570, 571-572)	1463 2	1900 2	3721 2	781
Time	24 Karat (502)	1580 2	1876 2	3854 2	490
Benefit Trust Life	Tele-Med	1443	1822	3878	1257
Bankers Life and Casualty	VIP V (CR-G002)	1245 2	1625 2	3382 2	None
Bankers Multiple Line	The Spectrum Plan (D-G002)	1245 2	1625 2	3382 2	None
Unian Bankers	The Spectrum Plan (MM-89)	1245 2	1625 2	3382 2	None
Blue Shield of California*	Preferred	1952	1952	3299	None
Blue Cross and Blue Shield of New Jersey	Blue Care	1261 2	1261 2	3400 2	Included
Blue Cross of Washington and Alaska*	Traditional Individual in Alaska	1933	1933	4123	None
Blue Cross of California*	Personal Prudent Buyer	1680	1680	3888	3360
Blue Cross and Blue Shield of Illinois*	Non-Group Comprehensive	1838 13	1992 13	4886 13	None
Blue Cross and Blue Shield of Maine	Blue Alliance	1294 15	1294 15	2580 15	Included
Empire Blue Cross Blue Shield	Tradition Plus Comprehensive (LGL 3253)	1507 14	1507 14	3228 14	Included
Benefit Trust Life	MM2	1496	1751	3603	None
Blue Cross and Blue Shield of Arizona*	Preferred Care	716	716	1928	None
Aid Association for Lutherans	TotalMed II (4945)	1708 2	1724 2	4032 2	1860

Better ◀——▶ Worse

than 90 percent. A policy with a ○ paid at least 81 percent, and a policy with a ◒ paid at least 75 percent of the expenses.

5 Lifetime maximum. Total benefits a policy will pay over a policyholder's life.

6 Maternity coverage. This shows the quality of the maternity rider that covers routine pregnancies and deliveries. If a policy offered coverage for complications only if policyholders buy a rider for routine coverage, it scored a ● It scored a ◒ if it offered coverage for complications without requiring purchase of the rider.

7 Renewability. Guaranteed means the policy is guaranteed renewable for the policyholder's life. **Conditional** means that the company can cancel it along with all similar policies. **Optional** means the company can cancel an individual policy.

8 Rate history. A ◉ indicates that over a five-year period the company has raised rates on the policy less than the medical consumer price index, which averaged 7.2 percent each year over the period. A ◒ means that it raised rates at least 17 percent a year.

9 Preexisting illness. The **waiting period** is the number of **months** a policyholder must wait before coverage begins for a preexisting illness not disclosed on the application. The waiting period may be shorter for disclosed illnesses. The **look-back period** is how far back in time the insurance company will investigate for preexisting illness.

10 Available to anyone. A "yes" indicates the policy is available to any applicant regardless of health status.

11 Exclusion riders. A "yes" indicates the company will issue coverage with exclusions for certain conditions or for certain parts of the body.

12 Higher rates. A "yes" means the company will issue coverage but at higher premiums for some medical conditions.

13 Other coverage. Additional coverages and features a policy may offer. See Key.

Quality index	3 Payout: Single	3 Payout: Family	Catastrophic claims	Lifetime maximum	Maternity coverage	Renewability	Rate history	Waiting period, mo.	9 Preexisting illness: Look-back period, mo.	Available to anyone	Exclusion riders	Higher rates	Other coverage	Comments	Telephone
2			4	5	6	7	8			10	11	12	13		
85	89%	89%	◉	None	◉	Conditional	◉	24	3	No	Yes	Yes	a,b,c	A	800-382-2000
83	84	87	◉	None for basic policy	◉	Conditional	◒	12	12	Yes	No	No	a,c,d	C	717-255-0820
81	82	68	◉	$1-million per condition	○	Guaranteed	◉	24	24	No	Yes	Yes	a,d	B	800-247-2190
80	88	88	◉	None	◉	Conditional	—	12	12	No	No	No	a,c,e	C	201-822-4500
80	86	85	○	1-million	◉	Guaranteed	◉	24	24	No	Yes	Yes	a	C,G	708-615-1500
80	83	82	◉	1-million	◉	Conditional	—	11	24	No	No	No	a,d,h	C	212-490-4757
80	83	83	◉	None for basic policy	◉	Conditional	○	12	12	Yes	No	No	a,c	C	215-564-2100
79	76	72	◉	None	◒	Conditional	◉	24	3	No	Yes	Yes	a,c,h	—	800-382-2000
78	74	60	◉	2-million	○	Guaranteed	—	24	24	No	Yes	Yes	a,d	D	800-247-2190
77	75	61	◉	1-million per condition	○	Guaranteed	—	24	24	No	Yes	Yes	a,d	—	800-247-2190
75	82	67	—	1-million	◒	Conditional	—	12	12	No	Yes	No	a,c,d	E	800-752-6663
75	75	60	—	None for hospital	○	Conditional	◉	12	24	No	Yes	No	a	J	800-392-5705
75	73	61	—	1-million	◒	Optional	◉	12	12	No	No	No	a,c,h	E	312-938-7209
74	68	62	—	None	◉	Conditional	—	12	12	No	No	No	a,c	F	406-444-8210
74	68	62	—	None	◉	Conditional	—	12	12	No	No	No	a,c	F	406-444-8210
74	74	74	◉	None for basic policy	◉	Conditional	—	12	12	Yes	No	No	a,e,f	C	201-822-4500
74	82	68	—	1-million	○	Conditional	—	12	No limit	No	Yes	No	a	B,E	800-522-4075
74	77	72	—	1-million	◉	Optional	◉	12	6	No	Yes	No	a,c,h	K	918-560-2121
74	73	72	—	1-million	◉	Conditional	◒	9	No limit	No	Yes	No	a,c,d	—	800-992-2308
73	73	60	◉	1-million	○	Conditional	◉	12	24	No	Yes	Yes	a	—	402-397-1111
73	72	60	◒	2-million	○	Conditional	◉	24	12	No	Yes	Yes	a	—	800-333-1203
72	71	58	◒	2-million	○	Conditional	—	24	12	No	Yes	Yes	a	—	708-615-1500
71	75	64	◉	None	◒	Conditional	◉	24	24	No	Yes	Yes	a,g	—	312-777-7000
71	75	64	◉	None	◒	Conditional	◉	24	24	No	Yes	Yes	a,g	—	312-777-7000
71	75	64	◉	None	◒	Conditional	◉	24	24	No	Yes	Yes	a,g	—	214-939-0821
71	73	60	—	2-million	◒	Conditional	—	12	12	No	Yes	No	a,c,d	E	800-624-5150
71	70	70	◒	100,000 per year	◉	Conditional	—	12	12	No	No	No	a,e	—	201-822-4500
71	75	60	—	1-million	◒	Conditional	◒	12	12	No	Yes	No	a	—	800-752-6663
71	68	55	—	2-million	◒	Conditional	—	6	6	No	Yes	No	a,c	E	800-777-6000
71	70	56	—	1-million	◒	Optional	◉	12	12	No	No	No	a	—	312-938-7209
70	67	72	—	None for basic policy	◒	Conditional	◉	12	No limit	Yes	Yes	No	a,f	C,G	800-482-0966
70	61	59	◉	500,000	◉	Conditional	—	11	24	Yes	No	No	a,d,h	—	212-490-4757
69	72	60	○	1-million	◒	Guaranteed	◉	24	24	No	Yes	Yes	a	C,G	708-615-1500
69	75	62	—	1-million	◒	Conditional	—	11	No limit	No	Yes	No	a,c,h	E	800-543-2944
69	71	60	◒	2-million	○	Conditional	◉	24	No limit	No	Yes	Yes	a,d	—	414-734-5721

Ratings
Continued

	Policy	Annual premiums [1] Men	Women	Family	Maternity rider
Blue Cross and Blue Shield of Indiana*	Comprehensive Value	$ 928	$ 987	$2108	$1164
Blue Cross and Blue Shield of Virginia*	Personal Health Care	2044 [12]	2044 [12]	4359 [12]	Included
Blue Cross and Blue Shield of Virginia*	Personal Health Care (Healthy Virginian)	1169 [12]	1169 [12]	2454 [12]	Included
Blue Cross and Blue Shield of Florida*	Preferred Patient	1882	2085	4558	None
Blue Cross of Washington and Alaska*	Traditional Individual in Washington	1320	1320	2844	None
Blue Cross and Blue Shield of South Carolina	Mark Four	963	1292	2312	671
Blue Cross and Blue Shield of Kansas*	Afforda-Care	1208	1208	2653	Included
Blue Cross and Blue Shield of Kentucky*	BCBS 3082	765	1123	1918	Included
Metropolitan Life	Major Medical Expense Plan (FAH 15-86)	1594 [14]	2042 [14]	4030 [14]	770
Certified Life	VIP Variable Individual Protection (CER-G002)	1245 [2]	1748 [2]	3382 [2]	None
First National Life	Major Medical (MM-286)	1005 [16]	1137 [16]	2142 [16]	748
Blue Shield of California*	Coronet	2941 [14]	2941 [14]	4229 [14]	None
Pyramid Life	G91	1501 [2]	1863 [2]	4015 [2]	645
Golden Rule	Inflation Guard GRI-H-1.4	1805	1990	3623	316
Blue Cross and Blue Shield of Arizona*	ExecuCare	940 [14]	940 [14]	1814 [14]	None
Prudential	Pru-Med (PM-83)	1228 [2] [14] [17]	1584 [2] [14] [17]	3127 [2] [14] [17]	2640
Washington National	Classic Choice (AM2836)	1764 [2]	2205 [2]	3249 [2]	900
Hospital-surgical					
Capital Blue Cross w/Penn. Blue Shield	Blue Cross Hospital and Blue Shield Plan 100	1579 [18]	1579 [18]	3451 [18]	Included
Independence Blue Cross w/ Penn. Blue Shield	Blue Cross Hospital and Blue Shield Plan 100	1968 [18]	1968 [18]	4729 [18]	Included
Blue Cross and Blue Shield of Michigan*	Non-Group Option E	2004 [19]	2004 [19]	3742 [19]	Included
Blue Cross and Blue Shield Rochester*	Non-Group Basic	1016 [18]	1250 [18]	2472 [18]	Included
Blue Cross and Blue Shield of Alabama*	Non-Group	1216 [20]	1216 [20]	2966 [20]	Included
Blue Cross and Blue Shield of Oklahoma*	Health Check Basic	756 [9]	756 [9]	1848 [9]	Included
Metropolitan	Tower Hospital and Medical-Surgical Expense	1015 [18]	1162 [18]	2846 [18]	None
Blue Cross and Blue Shield of Maine	Blue Cross with Blue Shield H	1033 [18]	1033 [18]	2058 [18]	Included
Blue Cross and Blue Shield of Montana*	Essential Care Plan	814 [8]	814 [8]	1844 [8]	Included
Blue Cross and Blue Shield of Ohio*	Non-Group Policy w/Catastrophic Rider	1266 [18]	1266 [18]	2683 [18]	515
Blue Cross and Blue Shield of New Jersey	Direct Payment Comprehensive Hospital and Series 14/20	1336 [18]	1336 [18]	2796 [18]	Included
Blue Cross and Blue Shield of New Jersey	Co-op Protection Plan and Series 14/20	1992 [18]	1992 [18]	3439 [18]	Included
Bankers Life and Casualty	Hospital Surgical Protection (CR-G020)	806 [2]	1043 [2]	2137 [2]	None
Bankers Multiple Line	Hospital Surgical Plan (D-G020)	806 [2]	1043 [2]	2137 [2]	None
Union Bankers	Major Hospital Surgical (HS-89)	806 [2]	1043 [2]	2137 [2]	None
State Farm Mutual Automobile	Basic Hospital-Surgical 97047IL	705 [4]	853 [4]	2177 [4]	None
Certified Life	Hospital Surgical Protection (CER-G020)	806 [2]	1043 [2]	2137 [2]	None
Pyramid Life	G95	1016 [2] [13]	1250 [2] [13]	2472 [2] [13]	645
Hospital-only					
Empire Blue Cross Blue Shield	Tradition Plus Hospital	839 [18]	839 [18]	1886 [18]	Included

[1] *$500 deductible on hospital services only*
[2] *Rates for nonsmokers.*
[3] *$350 deductible on nonhospital only.*
[4] *$500 deductible for each condition every 3 years.*
[5] *$300 deductible only for supplies and drugs.*
[6] *$250 for nonhospital services.*
[7] *$300 deductible.*
[8] *$200 deductible.*
[9] *$200 deductible for each hospital admission.*
[10] *$500 deductible on nonhospital only.*
[11] *$400 deductible.*
[12] *$750 deductible.*
[13] *$300 deductible for each hospital admission; $500 for all services.*
[14] *$1000 deductible.*
[15] *$200 deductible for nonhospital services.*
[16] *Atlanta rates; $500 deductible for each condition.*
[17] *$100 deductible for hospital inpatient stays only; $1000 for other services.*
[18] *No deductible required.*
[19] *$250 deductible.*
[20] *$60 deductible for each hospital admission.*

Key to Other Coverages
a–Prescription drugs for home use.
b–Preventive care for all ages.
c–Participating physicians for all families.
d–Mammography.
e–Pap smears.

	Quality index	Payout: Single	Payout: Family	Payout: Catastrophic claims	Payout: Lifetime maximum	Maternity coverage	Renewability	Rate history	Preexisting illness: Waiting period, mo.	Preexisting illness: Look-back period, mo.	Preexisting illness: Available to anyone	Preexisting illness: Exclusion riders	Preexisting illness: Higher rates	Other coverage	Comments	Telephone
	2			4	5	6	7	8			10	11	12	13		
	69	74%	60%	—	$1-million	○	Conditional	—	12	No limit	No	Yes	No	a	—	800-522-4075
	68	66	65	—	1-million	●	Conditional	●	12	No limit	Yes	No	No	a,c	K	800-553-3164
	68	66	65	—	1-million	●	Conditional	●	12	No limit	No	No	No	a,c	K	800-553-3164
	68	70	62	—	1-million	◒	Conditional	●	24	24	No	Yes	Yes	a,c,d,h	E	305-596-7600
	68	74	61	—	1-million	◒	Conditional	○	12	12	No	Yes	No	a,d	—	800-752-6663
	67	70	58	◓	1-million	○	Conditional	◓	12	No limit	No	Yes	No	a	—	800-868-2500
	67	70	67	—	1-million	●	Optional	●	8	No limit	No	Yes	No	—	M	913-232-1622
	67	71	68	—	1-million	●	Conditional	●	9	No limit	No	Yes	No	a,c,h	M	502-423-2011
	65	62	51	◓	1-million	○	Conditional	—	24	60	No	Yes	Yes	a	—	212-578-2211
	64	75	64	●	None	◒	Conditional	●	24	24	No	Yes	Yes	a,g	—	312-777-7000
	64	65	53	●	1-million	○	Conditional	●	24	24	No	Yes	Yes	a	—	205-832-1850
	63	65	53	—	2-million	◒	Conditional	◒	12	12	No	Yes	No	a,c,d	—	800-624-5150
	63	72	60	◓	2-million	○	Conditional	◒	24	24	No	Yes	Yes	a,d,e	—	913-722-1110
	62	74	60	●	1-million	○	Conditional	◒	12	24	No	Yes	No	a	—	817-297-4123
	61	62	51	—	1-million	◒	Conditional	○	11	No limit	No	Yes	No	c	—	800-543-2944
	61	63	55	○	None	○	Optional	●	24	24	No	Yes	Yes	—	G,H	201-802-2642
	61	71	59	◓	2-million	○	Conditional	○	24	12	No	Yes	Yes	a	—	708-570-5500
	81	77	80	●	None	●	Conditional	●	12	12	Yes	No	No	c,d	C	727-255-0820
	77	76	77	●	None	●	Conditional	○	12	12	Yes	No	No	c	C	215-564-2100
	76	70	70	—	None	◓	Conditional	◓	6	6	Yes	No	No	c	B,L	313-225-8000
	76	76	75	—	None	●	Conditional	●	12	No limit	Yes	No	No	f	B,H	800-847-1200
	71	63	66	—	None	●	Conditional	●	9	12	Yes	No	No	—	B,H,K	205-988-2200
	70	71	75	—	500,000	●	Optional	—	12	6	No	Yes	No	c	B,H	405-841-9797
	68	58	50	◓	none	◒	Guaranteed	●	24	60	No	Yes	Yes	—	B,G,H	212-578-2211
	67	55	53	—	none	◓	Conditional	●	12	No limit	Yes	Yes	No	f	B,G,H	207-775-3536
	67	59	59	—	1-million	◓	Conditional	—	12	12	No	No	No	c	F	406-444-8210
	66	62	66	—	1-million	●	Optional	●	12	No limit	No	No	No	a,i	B,G,I,N	216-687-7218
	62	65	67	○	None	●	Conditional	◒	12	12	No	No	No	f	B,H	201-822-4500
	61	63	66	○	None	●	Conditional	◒	12	12	Yes	No	No	f	C,H	201-822-4500
	58	52	45	◓	None	◒	Conditional	◓	24	24	No	Yes	Yes	—	—	312-777-7000
	58	52	45	◓	None	◒	Conditonal	◓	24	24	No	Yes	Yes	—	—	312-777-7000
	58	52	45	◓	None	◒	Conditional	◓	24	24	No	Yes	Yes	—	—	312-777-7000
	53	55	45	◓	1-million	◒	Optional	—	24	24	No	Yes	Yes	—	—	309-766-2311
	50	52	45	◓	None	◒	Conditional	◓	24	24	No	Yes	Yes	—	—	312-777-7000
	42	35	30	●	2-million	○	Conditional	—	24	24	No	Yes	Yes	j	B,G,H	913-722-1110
	67	68	72	◒	None	●	Conditional	●	11	24	Yes	No	No	d	B	212-490-4757

f–Participating physicians for families below some income levels.
g–$50/year for preventive care per person.
h–Well-child care.
i–Major-medical coverage after $2500 deductible is met.
j–Major-medical coverage after $25,000 of covered expenses are incurred.

Key to Comments

A–Coinsurance on hospital and $10 copayments for physicians' visits.
B–No coinsurance.
C–Coinsurance only for certain services.
D–Less coinsurance after the first year.
E–If PPO doctors not used, coinsurance and coinsurance maximums are higher.
F–30 percent coinsurance.
G–Pays a set amount for hospital room and board.
H–Surgical-fee schedule.
I–Pays set amount for all services for each day in the hospital.
J–Routine maternity rider offered only with family policies.
K–Routine maternity coverage is included as part of policy only with family policies.
L–Maternity coverage only for delivery and hospital stays—no doctor visits covered.
M–Routine maternity coverage and coverage for maternity complications offered only with family policies.
N–No maternity coverage even for complications unless rider is purchased.

CONTINUING COVERAGE

WHEN YOU LEAVE A GROUP PLAN

If you leave a job, you may have two options for continuing your health insurance short of shopping for an individual policy on your own. Depending on the size of the firm you worked for and on your state's insurance regulations, you may be able to continue your group coverage for a short time as provided under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Or you may be able to obtain an individual policy through a process known as conversion. Both options, though, will usually cost a lot more than you would spend for group coverage.

Because it is less expensive and generally offers better coverage than a conversion policy, your first line of defense should be COBRA.

COBRA: How it works

If you worked for a business with 20 or more employees, COBRA entitles you and your dependents to continued coverage for at least 18 months under your former employer's plan. If you are disabled and eligible for Social Security disability benefits when your employment ends, you can obtain an additional 11 months of coverage, for a total of 29 months.

If you are insured through your spouse's plan at work and your spouse dies, you become divorced or separated, or your spouse becomes eligible for Medicare, COBRA provides for coverage of up to 36 months.

COBRA requires that you pay 102 percent of your group insurance premium. If your employer has been paying a portion, you will have to assume that cost in addition to what you were already paying, plus an extra 2 percent for administrative costs. Disabled people who take COBRA coverage must pay as much as 150 percent of the premium for the extra 11 months.

You can lose coverage if you don't pay the premiums, if you become eligible for Medicare, if your employer discontinues health insurance for employees still working there, or if you join another plan.

However, if you join another plan and have an existing medical condition for which that plan imposes a waiting period, you can still keep your COBRA benefits until they would normally run out. By that time, your preexisting condition may be covered under the new plan. But you could be without coverage for that condition if your COBRA benefits stop before the waiting period on the new policy is over.

If you work for a company that has self-insured its workers' health coverage, you are entitled to COBRA benefits, even though such plans are normally exempt from other insurance regulations.

If you are not eligible for COBRA because your former firm employs fewer than 20 workers (or is a church organization), you may still have some protection under state laws. If your state provides for "continuation" of benefits, you may be able to stay on your employer's group policy for as little as three months in some states or as long as 18 months in others. (Those benefits are usually not available to workers in self-insured plans.)

The following states do *not* have comprehensive continuation laws: Alabama, Alaska, Arizona, Delaware, Florida, Hawaii, Idaho, Indiana, Louisiana, Michigan, Mississippi, Nebraska, Pennsylvania, Wisconsin, and Wyoming.

Some employers consider COBRA an administrative headache and may offer employees who leave a simpler alternative—insurance that covers them only for injuries caused in an accident. Accident-only policies may be tempting because they're cheap—a few hundred dollars a year, compared to a few thousand for COBRA coverage—but we don't recommend them. Unless you are very young, you're much more likely to need coverage for illnesses than for accidents.

Beyond COBRA

After COBRA coverage runs out, or if you're not eligible for it, your next options are to take a conversion policy or shop for individual coverage. (Unless, of course, you're covered under a new employer's health plan or become eligible for Medicare.)

The law requires that every employer who normally offers conversion policies to workers who leave also offer them to former employees once their COBRA benefits run out. Fifteen states, as well as the District of Columbia, don't require employers to offer conversion policies to employees who leave. They are: Alabama, Alaska, Connecticut, Delaware, Hawaii, Idaho, Indiana, Louisiana, Massachusetts, Michigan, Mississippi, Nebraska, New Jersey, North Dakota, and Oklahoma.

If an insurance company terminates a group plan, employees may also be out of luck. Two-thirds of the states require insurers that cancel group policies to offer conversion options to people losing their coverage.

Even when it is offered, conversion coverage is almost always inferior to what you received from your group plan. (Twenty-four states require companies to offer conversion policies with major-medical or comprehensive benefits.) If you currently have major-medical coverage, a conversion policy may provide only hospital-surgical benefits and only pay up to a fixed amount each day for hospital room and board and surgical procedures (see page 7).

For example, CIGNA, an insurer that offers several conversion options to employees converting from the group policies it underwrites, pays only $250 for hospital room and board if an employee chooses its top-of-the-line conversion coverage. For employees in a top-of-the-line group policy, CIGNA would pay most of the hospital charge, which runs considerably more than $250. (The average cost of a day in the hospital is about $800.)

While benefits are low, the prices of conversion policies are high, reflecting the fact that it is mostly people in poor health who buy this coverage. CIGNA, for example, charges a 45-year-old man or woman living in Chicago an annual premium of $4736 for its most generous conversion policy with a $500 deductible. By comparison, American Republic, the top-ranked commercial company in our study, would charge a 45-year-old man in Chicago $1904; a 45-year-old woman, $2240.

Despite those drawbacks, a conversion policy may be your only option if you have health problems. (Insurers must make these policies available to anyone regardless of their health.)

If only one member of your family suffers from some medical condition, you may want to take the conversion policy for him or her and try to find cheaper, individual coverage for the rest of the family. In some states, a person with health problems may be eligible for coverage from the high-risk pool, although in certain states, if you're eligible for a conversion policy, you can't have pool coverage.

If you're considering buying an individual policy instead of taking your conversion option when COBRA coverage ends, do your shopping well in advance. The slightest health problem can disqualify you, and it may take time for an insurer to collect your medical records and decide if it's willing to issue coverage. Once your COBRA benefits run out, you have only 31 days in most states to sign up for a conversion policy.

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RO102

THE CRISIS IN HEALTH INSURANCE

In the first part of this series, we looked at the problems millions of Americans have in obtaining and keeping health insurance. We evaluated 71 individual health-insurance policies sold by 40 commercial carriers and Blue Cross and Blue Shield organizations, and discussed other alternatives for people who lose their group insurance.

In Part 2, we go beyond the short-term remedies to examine the various solutions to the health-insurance crisis that have been proposed by insurance companies, physician organizations, and the business community. We also visit Canada to look at how that nation pays for its health care. The Canadian example is considered by some as a model for the U.S.

HEALTH INSURANCE FOR ALL?

The American health-care system is the costliest in the world. The U.S. spends 171 percent more on health care per person than Great Britain; 124 percent more than Japan; 88 percent more than West Germany; and 38 percent more than Canada.

Over the last five years, the cost of health care in the U.S. has risen 42 percent, faster than the cost of food, housing, or transportation. In 1990, the nation's medical bill will total some $666-billion, or about $2664 for every man, woman, and child. Health-care spending now consumes 11½ percent of Gross National Product; by the end of the decade, it could account for as much as 15 percent.

Not all of those dollars pay for medical treatment. The cost of administration, claims handling, and insurance-company bureaucracy eats up at least $65-billion, almost 10 percent of the total. "We waste more of our medical dollars on bureaucracy and paper pushing than any other country," says Dr. David Himmelstein, national coordinator of Physicians for a National Health Program.

Despite the vast sums poured into health care, the U.S. ranks 12th in life expectancy, behind Japan, Italy, France, and the Scandinavian countries. It ranks 21st in the number of deaths of children under age 5; 22nd in infant mortality; and 24th in the percentage of babies born with an adequate birthweight (Bulgaria, Hong Kong, and the Soviet Union all do better on that last measure).

Among industrialized nations, only the U.S. and South Africa fail to provide access to health care for all their citizens.

A joint venture

The U.S. health-care system is built on a lucrative partnership of fee-for-service medicine and private insurance. For years, doctors and hospitals had carte blanche to set their own fees and pass the cost of their services along to private insurance carriers or to their patients. Insurance companies (and patients) rarely questioned the amount of those bills. "No one ever paid us to go fight with doctors," says one insurance executive.

If fees rose higher than the premiums the insurance companies needed to pay claims and turn a profit, the insurers simply raised the price of coverage. Policyholders could either pay the higher premiums or go uninsured.

The cost of medical care has now forced insurance premiums so high that millions of people *are* going uninsured. "The whole system keeps pricing more and more people out of it," admits Howard Bolnick, president of Celtic Life, a seller of health insurance. "The mar-

ket is working efficiently, but it's less than optimum from society's point of view."

Decades of debate

As more people are squeezed out of the American health-care system, and as basic public-health statistics underline the system's comparative inadequacies, a decades-old debate over public-health policy has been rekindled. The debate has been simmering for some 80 years.

In the years before World War I, in the 1930s, in 1949, in 1965, and again in the 1970s, the U.S. seemed on the verge of establishing universal health insurance. A 1939 issue of CONSUMER REPORTS noted: "There is now no doubt of the growing wave of popular sentiment in favor of an efficient public health program. It has become obvious that the people of the country intend to see to it that the whole population shall benefit from the discoveries of modern medical science. The only question before the country now is 'how soon?'"

A decade later, in 1949, we reported: "As the new Congress meets, prospects for national health insurance have never looked better. There are a number of reasons why 1949 may see a Federal insurance law passed at last. The American public has overwhelmingly demonstrated its approval of health insurance in many surveys, in legislative programs of consumer, civic, and labor groups, in government policy reports, and in endorsements by political leaders. Soaring prices have made the cost of medical care even more difficult for most families to afford."

Sixteen years later, a national health-insurance program still hadn't come to pass, despite the committed leadership of President Lyndon Johnson. In 1965, after powerful lobbying against national health insurance by organized medicine, Congress voted to authorize it only for the elderly, in the form of Medicare. (At the same time, it established Medicaid, a new government program for the poor.)

Even then, the Medicare Act was tailored to the economic demands of the American Medical Association and Blue Cross and Blue Shield, the primary insurance carrier of the day. Fee-for-service medicine and the Blue Cross method of reimbursing health-care providers became part and parcel of Medicare. They laid the foundation for today's towering health-care costs. (Blue Cross and Blue Shield also got the job of paying Medicare claims for the Government.)

Again in the 1970s, there was serious talk of universal health insurance. But President Jimmy Carter could not muster the political backing needed to fulfill his campaign pledge to implement it.

How has a system that costs so much and still falls short managed to survive and resist reform?

The power of the AMA

Fearful that universal health insurance will lower the incomes of its 271,000 members, the American Medical Association has for years denounced national health insurance as "socialized medicine." More to the point, the AMA has paid politicians handsomely to view national health insurance in the same light.

The AMA is one of the largest contributors to political campaigns, appearing near the top of almost every list of the big money raisers, the big contributors, and the big trade association political action committees (PACs) compiled by the Federal Elections Commission.

During a 15-month period ending in March 1990, the AMA ranked second on the election commission's list of the top 50 PACs in amount of receipts, second in total spending (which includes funds for advertising and mailings as well as contributions), and seventh in the amount of cash on hand, with some $2-million in reserve to bankroll future campaigns.

In the 1988 Congressional elections, the AMA spent $5.3-million, including $2.3-million in direct contributions to House and Senate candidates. From January 1989 through March 1990 it has given money to 348 members of Congress, including eight of the 12 Congressional members of the Pepper Commission, a bipartisan group composed of members of Congress and industry representatives that was established to study health-care financing and recommend changes. The Commission was chaired by Sen. John D. Rockefeller IV, D-W.Va.

To replenish its coffers, the AMA embarked on a special effort last year to discredit the Canadian health-care system, often viewed as a model for reform in the U.S. In what it called its "Strengthening the U.S. health-care system" campaign, the AMA wrote to member physicians: "We need your help to continue reaching millions of Americans. We must tell them the facts about the dangers in a Canadian-type health-care system—before it's too late. Help us continue publishing our messages in leading magazines and newspapers...." Enough doctors sent checks that the AMA was able to buy ads disparaging the Canadian system in major magazines. (For one example, see the illustration on page 3.)

The AMA's national political program is reinforced by the efforts of state medical associations. From early 1989 to the end of March, state medical associations in 10 states spent some $4.1-million on behalf of political candidates.

Insurance clout

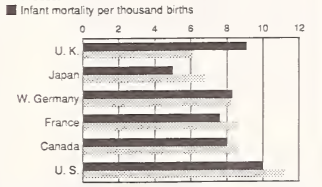
The insurance industry's stake in the battle is the $175-billion it collects each year in health-insurance premiums. In a letter sent to member companies last summer, Carl Schramm, president of the Health Insurance Association of America (HIAA), warned that "a move in the United States to a Canadian approach to health-care financing is antithetical to our interests." Schramm subsequently told CU: "We'd be out of business. It's a life-and-death struggle."

The insurance industry also shovels money at politicians. American Family Corp., the fifth-largest seller of health insurance, particularly dread-disease and cancer policies, ranks eighth on the election com-

Doctors on the picket line: Just as organized medicine in the U.S. has opposed universal medical insurance, many Canadian physicians were none too fond of the notion. When Saskatchewan became the first province to adopt universal medical coverage, doctors there went on strike. When Quebec followed suit in 1970, its doctors also staged a short strike.

HIGH COSTS, POOR RESULTS

Though the U.S. spends a higher percentage of its Gross Domestic Product on health care than these five other industrialized nations, its record on infant mortality is the poorest of the group. (Gross Domestic Product is the monetary value, at market prices, of all goods and services created in a country in a given year. Infant mortality is a commonly used measure of the overall health of a nation, reflecting how well medical services are delivered throughout its population.)



Sources: Health Care Financing Review, 1989, Annual Supplement; UN Children's Fund, State of the World's Children, 1989; Organization for Economic Cooperation and Development, Health Data Bank.

mission's list of the top 50 corporate campaign contributors, ahead of such giant corporations as Boeing, Citicorp, and Ford Motor Co. It donated some $250,000 from the beginning of 1989 through March of 1990. Three other large sellers of health insurance—The Travelers, Metropolitan, and Prudential, all of which collect well over $1-billion in health-insurance premiums each year—are also among the top 50 corporate contributors.

But the insurers don't limit themselves to campaign contributions. Their forte is "educational" lobbying. "We produce lots of research bulletins that are classy little numbers," HIAA president Schramm told CU. When the Pepper Commission issued its report in March 1990, its recommendations for reforming sales practices in the small-employer market were strikingly similar to those of the HIAA. "The Pepper Commission basically ceded the small-group issues to us," Schramm says. "They [the commission's recommendations] are our proposals."

Changes in the wind

But public dissatisfaction with the current system has once again brought health insurance onto the national agenda. Poll after poll shows that the American people are unhappy with the way their health care is financed. A 1988 poll conducted by Louis Harris and Dr. Robert Blendon, chairman of the Department of Health Policy and Management at the Harvard School of Public Health, found that 61 percent of Americans would prefer a system of national health insurance like the one in Canada, in which "the government pays most of the cost of care for everyone out of taxes, and the government sets all fees charged by doctors and hospitals." In 1990, a Los Angeles Times poll asking a similar question found that 66 percent of Americans would prefer a health-insurance system similar to Canada's. "People are far ahead of the political leadership on this issue," says Susan Sherry, an official at Families USA, a senior citizens health-advocacy group.

The business community has also become vocal on the issue. Some corporate leaders are calling for changes that they would have considered unthinkable a few years ago. "We need fundamental reform. Whether we have the courage to move forward remains to be seen," says Walter Maher, a lobbyist for Chrysler Corp. Chrysler says that workers' health insurance adds $700 to the cost of every car it builds in the U.S.—an amount that must come down if the company is to remain competitive.

Not all doctors side with the AMA. The 68,000-member American College of Physicians is calling for reforms that would guarantee all Americans access to medical services and reduce the waste and inefficiency in the present system. The 3000 members of Physicians for a National Health Program have a similar goal. (Those groups, however, don't back their programs with political contributions.)

Privately, even some insurance-industry executives recognize that universal health insurance is probably inevitable, and they have been preparing for their eventual role in it. "Some companies are saying, 'If we can survive until there's national health insurance, we have a shot at administering it,'" says an official at one Blue Cross and Blue Shield organization.

Solving the crisis

A number of remedies for the health-insurance crisis have been proposed by various interest groups. Some are limited; others are more far-reaching. Some deal only with controlling costs of the health-care system. Others confront the more basic question of providing access to care for everyone. Among the proposals likely to be part of the public debate in the coming months are these:

1. Encourage people to use fewer medical services by writing higher deductibles into policies. The theory behind this proposal is that when people pay a greater share of their bills, they'll use health care more frugally. As a result, the argument goes, health-care costs will decrease, premiums will rise more slowly, and more people will be able to afford coverage.

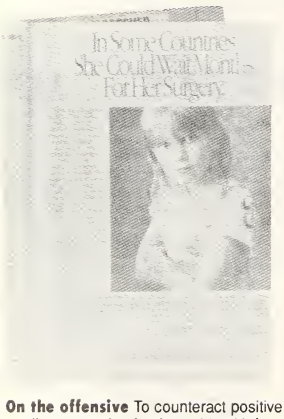
Such a notion assumes that people prescribe their own medical care. Most of the time they don't; their doctors do.

Health-care providers also stimulate much of the demand for elective medical care. Hospitals now advertise in magazines, on television, and on billboards—drumming up business for their inpatient psychiatric services, for example, when such cases might be handled more appropriately on an outpatient basis. As part of its corporate-image promotion, General Electric advertises magnetic resonance imaging machines (MRIs) on television. "It doesn't hurt to have people aware of MRIs," says a GE spokesperson. If people ask for MRIs instead of ordinary X-rays, hospitals will have no choice but to shell out $1.4-million to $2-million for a machine.

Higher deductibles may indeed make some people think twice before seeking care in the first place. While discouraging unnecessary services is a reasonable goal, there's an obvious danger that people will postpone *necessary* treatment. Then more costly procedures may be necessary, or it may be too late.

There is even some doubt as to whether any savings would result from a switch to higher deductibles. "Our experience has shown that higher deductibles have not prevented our [claim] costs from going up," says Andy Perkins, a vice president at The Travelers.

2. Do away with state-mandated benefits. Each state requires that health-insurance policies sold there include certain coverages. These so-called state mandates vary among states, but many require insurers to cover newborn babies, adopted children, prenatal care, and



On the offensive To counteract positive media portrayals of universal health insurance programs in Canada and elsewhere, the American Medical Association launched a national advertising campaign in 1989. This ad ran in Newsweek.

mammographic screening. They may also offer employees the option of continuing their coverage when they leave a job.

The insurance industry contends that some mandated benefits, such as coverage for visits to psychologists, podiatrists, chiropractors, and social workers, are of questionable value and unnecessarily raise the price of insurance. However, the industry has no estimate of the overall premium savings that would result.

In CU's view, repealing mandated coverage moves in the wrong direction—toward less access to care. To shave a few dollars off premiums, more women would lose their prenatal care, more newborns and children would go without preventive treatment, and more employees would have no coverage when they left their jobs.

3. Design stripped-down policies. Some insurance-company and Blue Cross and Blue Shield executives have suggested designing policies with limited benefits that they can sell for about half the price of more comprehensive coverage.

While such basic policies might improve the overall statistics on the uninsured, they, too, would result in less coverage for individuals. We reported on some of them in Part 1. An "affordable" basic policy from Blue Cross and Blue Shield of Oklahoma, for instance, covers only 21 days of hospital care. That might be enough for most sicknesses, but a catastrophic illness or injury would leave a policyholder uninsured and possibly on the road to bankruptcy. A person whose serious heart attack cost almost $50,000 would have been left $10,000 in debt by an affordable hospital-surgical policy sold by Pyramid Life, the policy that ranked at the bottom of our Ratings in Part 1.

4. Institute "managed care." Under the rubric of "managed care," insurance companies are belatedly paying attention to what their dollars are buying. Managed care includes formal programs for monitoring the quality of treatment and determining whether it's appropriate for the patient's condition. Some programs require policyholders to seek second opinions before undergoing surgery, to use hospital outpatient facilities for specified procedures, to use certain doctors and hospitals, and to obtain approval from insurance companies before starting a proposed course of treatment.

Managed care attempts to put controls on doctors—ironically some of the same controls doctors have feared from a national health-insurance program. In the process, it is creating a brand-new profession, health-care cost management, one of the fastest growing segments of the health-care industry. Health-care cost management firms are expected to generate some $7-billion in revenue in the next few years—revenue that will, of course, come from insurance premiums.

Whether the savings in the cost of health care will be greater than the money spent to "manage" it remains to be seen. "None of this stuff has done anything to make the fundamental health-care system cost less and [be] more efficient," says Curt Fuhrmann, president of the individual health division of Washington National. And even if managed care eventually reduces the nation's health-care bill, it will do nothing to expand access to medical services for people who currently have no insurance coverage.

5. Establish risk pools. The insurance industry wants each state to set up a high-risk pool that would provide policies for people the companies don't want to insure. Such pools are yet another way for the industry to shed a group of policyholders who are not profitable. The HIAA further proposes that the states pick up the tab for pools' losses; that is, make up the difference between what the pools collect in premiums and what they pay out in claims.

In the spring of 1990, when we surveyed the risk pools that had been organized in 19 states, we found that they covered only about 55,500 people in total, and all the pools were operating at a loss. Pool administrators estimated that at least 413,000 people in those states needed pool coverage but could,'t obtain it. In Illinois, for example, the waiting list was so long that people have to wait at least a year for coverage.

6. Expand Medicaid coverage. When Medicaid was first established in the mid-1960s, it covered some 70 percent of those with incomes below the poverty line. Today Medicaid covers just 38 percent, because states and the Federal government have raised their eligibility standards.

The insurance industry and the American Medical Association want to reverse that trend by requiring Medicaid to cover anyone whose income falls below the official poverty line, currently $12,675 for a family of four; $8075 for a couple; and $6314 for a single person.

Under some proposals, people whose incomes are as high as twice the poverty level could "buy" Medicaid benefits. Under other proposals, these people would have to turn to the private market for their coverage. It's hard to see how any family whose income is around $13,000—or even $26,000—can afford some of the policies we rated in Part 1. Premiums for families of four ranged from about $2000 to more than $6000 a year.

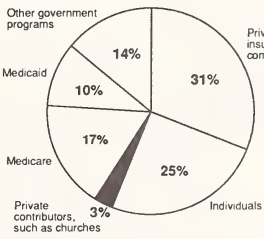
Expanding Medicaid is an easy solution for doctors and insurance companies. It costs them nothing. The burden will be borne by state and local treasuries, whose Medicaid budgets are already stretched to the limit.

Putting Medicaid cards into the hands of more people wouldn't necessarily assure them access to health care. Many doctors refuse to treat Medicaid patients because reimbursement rates are low. Reforming Medicaid would expand coverage for some, but it would also increase the government bureaucracy needed to determine eligibility. It is at best a stopgap measure that will do little to curb waste in the health-care system.

7. Reform insurance-company practices. One plan proposed by insurers themselves would excuse people who were once covered under a small employer's group policy from satisfying a new waiting period for pre-existing illnesses

WHO WRITES THE CHECKS?

As costly as the private-insurance system is, it pays only 31 percent of the U.S. health-care bill. At least 25 percent comes directly out of Americans' pockets.



Source: Paying More, Getting Less: How U.S. Health Care Measures Up, National Health Care Campaign, 1968.

Signs of the times Hospitals in some parts of the country now advertise to fill their beds, partly because of recent insurance-company rules requiring that more procedures be done on an outpatient basis. These two billboards beckon motorists along a New Jersey highway.

when their employers change carriers or when they change jobs. In those cases, people with health problems would have immediate coverage. This proposal would also prohibit insurers from excluding coverage for certain health conditions or parts of the body by means of exclusion riders.

But insurers still don't want to take on any unnecessary risk. So their proposal also calls for the establishment of a reinsurance agency (essentially a company that insures insurance companies) to assume the risk of waiving pre-existing conditions clauses and eliminating exclusion riders. Insurers themselves would fund the reinsurance program through assessments, but if assessments proved to be inadequate, the government could be called on to make up the difference.

Paying for long-term care: The Pepper Commission has recommended a publicly funded program to pay for nursing-home expenses and for home care needed by people of all ages. That would eliminate the need for most nursing-home insurance. CU supports this approach.

Another industry-sponsored proposal would limit the sometimes huge annual increases experienced by employees who work for small firms—to no more than 15 percent above an insurance company's general yearly rate increase for all its policyholders.

Both of those proposals would help people already safely inside the insurance loop. But they won't help people with health problems who are outside the system or who must buy their own coverage.

8. Require all employers to offer coverage. The main proponent of this approach is Senator Edward Kennedy. He is sponsoring a bill that would require all employers to offer insurance to employees who work at least 17½ hours a week. Under Kennedy's bill, employers would also have to pay 80 percent of the cost of a basic package of benefits for their full-time employees.

Others have proposed variations on Kennedy's plan. These so-called pay-or-play approaches to health-care coverage would require employers to offer insurance to their workers or pay into a special government-operated fund that would provide the coverage. In other words, employers would either "play" by providing coverage or "pay" into the special fund. The Pepper Commission recommended such a plan.

To win support of the AMA, Kennedy's bill does not address cost containment. More people would be covered, but most doctors and hospitals would still have a blank check. That omission, a serious one in CU's view, has also given employers and the insurance industry reason for opposing this approach.

Lobbyists for small business argue that the costs of providing coverage are too great for many marginal firms. Unless small businesses received tax relief in exchange for providing coverage, this approach could give them a powerful incentive to hire employees to work fewer than 17½ hours a week. Seasonal and part-time workers could still be left without insurance.

Congress is likely to give pay-or-play proposals serious consideration in the next few years. At best, these proposals can expand insurance coverage for some people. At worst, they fail to offer a way to curb health-care costs. They also perpetuate the current system of private insurance with all its administrative waste. In fact, they would add another layer of administrative bureaucracy in creating the special government fund for workers whose employers would still not provide coverage.

9. Introduce universal health insurance. This is the approach Canada has taken to fund medical care for its citizens. Under this system, everyone is entitled to health care, and the public pays the bills through tax dollars rather than through insurance premiums.

Providers of health care charge a fee for their services, just as in the U.S. But their fee schedules must be negotiated with the government, which has an incentive to control costs, since tax increases are as politically unpopular in Canada as in the U.S.

In CU's view, the first eight of these proposals fall short of the goal of affordable health care for all Americans. They would still limit employment options—forcing some people to stay on a job that may otherwise be unsatisfactory simply to keep their health insurance. They could still force a person to spend as much as $12,000 a year to cover a family under a conversion policy. Some sick people would still have to settle for an inferior hospital-indemnity policy just because it is better than nothing. Worst of all, many Americans would still be denied proper health

care simply because they couldn't afford to buy insurance.

Recommendations

The few reforms that were won in the past were simply bargains struck with doctors and insurance companies. People who could least afford the cost of medical care or insurance were sloughed off onto public programs. The public assumed the cost of health care for those patients through Medicare and Medicaid while health-care providers and insurance companies kept control of the system and retained for themselves the ability to profit from those who could pay.

Meaningful reform must provide for universal access to health care; cost containment; mechanisms to ensure quality of care; elimination of administrative waste; and long-term care for the elderly and disabled.

The only model for reform that attempts to meet those criteria is the Canadian system. It is not a system

Doctors vs. Insurers

THE BATTLE OVER FEES

Insurance companies and the Federal government say they're trying to control health-care costs. And in the process, they're going head to head with the medical establishment.

Insurers are now requiring many policyholders to obtain approval before beginning a course of treatment. They require that policyholders have certain types of surgery done in hospital outpatient facilities and that they obtain second opinions before having any surgery performed. They are also establishing preferred-provider organizations, PPOs, in which doctors agree to reduce their fees to the insurer in exchange for more patients; the insurer lowers deductibles and coinsurance as an inducement for policyholders to use PPO doctors.

Since 1984, the Federal government has limited the fees it pays to doctors who treat Medicare patients. It will soon implement a new way of paying doctors based on the relative value of the various services they perform. This new system is aimed at reducing the fees of some highly compensated specialists, such as anesthesiologists and radiologists, and increasing the fees of others, such as family doctors. The system also includes limits on billing and on the number of services performed.

So far, all these efforts at taming health-care costs have been about as successul as trying to squeeze a balloon. When insurers or the Federal government clamp down on costs in one area, costs expand rapidly in another. "We pay less per claim, but we pay for more claims," says Curt Fuhrmann, president of the individual health division of Washington National, a seller of health insurance. "A lot of this stuff works initially, but after a while the system adjusts and finds a way around it." Nowhere is that more evident than in the war over bills that has erupted between doctors and insurance companies.

The fine art of bill coding

Pressure from insurance carriers to limit physician payments, as Medicare does, has spawned a new industry devoted to teaching doctors how to bill for their services and maximize reimbursement. Firms in the business of "doctor reimbursement and coding" sell thick books and sponsor seminars that tell physicians how to beat the system.

"Reimbursement guaranteed. You'll improve your reimbursement, or you'll get your money back," reads an advertisement for one such company, Medbooks. "Start now to bill for *all* of the services you provide—and receive *all* of the payments you're entitled to!" reads a flyer for St. Anthony Publishing Inc., a company that proclaims it has grown into an industry leader in "five short years."

The primers sold by these new firms tell physicians how to choose certain billing codes over others that would net them less income. There are some 7000 codes representing all the services physicians perform, and doctors customarily list the codes on the bills they present to patients and their insurance companies.

For example, one newsletter reported that insurance companies are not paying if doctors use the code for "hospital discharge day management" when they discharge hospital patients. It advised doctors to use either the code for "medical conference by physician regarding medical management with patient, and/or relative, guardian, or other; approximately 25 minutes" or a code for a higher level of daily hospital visit. The newsletter recommended that doctors use both codes for a while and see which one insurance companies will go for.

A physicians' newsletter from St. Anthony Publishing carried this headline: "Updating superbill brings financial rewards." Superbills are the detailed bills that patients receive for the procedures doctors perform. St. Anthony advised doctors in family practice that adding and billing separately for such services as minimal [office] visits, brief [office] visits, injections such as tetanus and DPT, new patient office visits, supplies, and brief follow-up consultations could bring an increase in weekly revenue of $845, or $40,560 a year (based on 48 weeks).

The books and newsletters also offer guidance on "unbundling"—that is, charging separately for services that were once priced together or "bundled." Unbundling almost invariably means more income.

Another newsletter from St. Anthony Publishing described one medical office in which doctors were performing dilatation and curettage procedures 10 to 15 times a week. When the doctors were shown how to charge separately for dilatation and for curettage, and even for sterile surgical dressings, the average payment from insurance companies increased from $300 to $535, and the practice increased its revenue some 78 percent.

Insurers strike back

To combat these practices, insurance companies are now hiring firms to "rebundle" the bills that come into their claims departments. Indeed, a rival industry has sprung up to scrutinize bills for evidence of the billing practices promoted by the coding and reimbursement firms.

For instance, ERISCO, a subsidiary of Dun and Bradstreet, offers "medical claims editor" computer software that will rebundle a $2500 bill for performing an appendectomy ($1500) with a laparotomy ($1000), the latter being simply an incision in the abdomen. Once the computer program has rebundled the bill, the doctor will receive only $1500 for the appendectomy and nothing extra for making the incision.

No one knows yet whether insurers or doctors will win this war. What is certain is that the battles are costly and the money being spent on books, seminars, and software is doing little to improve the health of Americans.

of "socialized medicine," in which doctors and hospitals work for the government and patients are assigned to clinics. Canadians are free to pick their doctors and hospitals. The Canadian health-care system costs less than the U.S. system and delivers more, mostly because it spends less on administration and bureaucracy. Canada spends about 1 to 2½ percent of every health-care dollar on administering health claims, compared with 10 to 11 percent spent by private insurers in the U.S.

A move to a universal health-care system modeled on Canada's would save money in other ways. Because medical care would be available to everyone, there would be no need for medical-payments coverage under workers' compensation insurance or automobile-insurance policies, or for the liability portion of homeowners insurance that goes to cover injury claims.

As we explain in the following report, Canada has by no means found the ideal system. It is facing the same cost pressures on medical care as the U.S. and European countries, and, like those nations, it is examining ways to contain them. But public debate there has long since moved away from reforming insurance practices and toward targeting the country's resources to improve the health of its people.

The U.S. should take the best of the Canadian system and add to it the techniques that have shown the most promise for controlling health-care costs and curbing the overuse of health-care services that occurs in both countries. Those techniques include establishing "practice guidelines" for physicians (which define procedures that are effective under various circumstances) and assessing whether new technologies are effective in treating disease. Borrowing the best from Canada and adding effective cost containment would produce a uniquely American system that would serve all citizens.

It may be that the American model will evolve first in one of the states. (The Canadian system was patterned after universal hospital coverage introduced in the province of Saskatchewan in the 1940s.)

Some states are already looking for ways to improve access to health care for their residents. In California, for instance, there is a serious proposal in the legislature for the state to pay for health care, including long-term care, for all Californians. In New York, the state legislature recently passed a state-subsidized insurance plan for young children of the working poor, a step some see as a move in the direction of universal health insurance.

"In the next decade, if you don't have a national health system, the insurance companies will continue to selectively deinsure. No matter how many premiums you've paid, you'll never know if you'll be next," says Dr. Jane Fulton, a professor of health policy at the University of Ottawa. "That risk should be intolerable to Americans."

A LOOK AT THE CANADIAN ALTERNATIVE

Near downtown Montreal, a pregnant woman arrives at a *centre local de services communautaires.* Here at the CLSC, as the center is called, she receives regular checkups and counseling on the right foods to eat during her pregnancy.

When it's time for her to deliver, she will go to a local hospital. One of the two doctors who has been caring for her will deliver the baby. After the baby is born, she can bring it back to the CLSC for immunizations and follow-up care.

A social worker at the center will help her adjust to the demands of motherhood if she needs help, and a staff nurse will visit two weeks after the baby is born to give breast-feeding advice and answer other questions.

If the nurse finds that the mother lacks the skills to care for her baby, or detects more serious problems such as child abuse or neglect, more intensive counseling, either in the mother's home or at the CLSC, will be scheduled. When the mother needs a break, she can take the baby to the CLSC's day-care center, where women from the surrounding community drop off their children for a few hours each week.

The woman will pay nothing for these services. She simply presents her orange-and-yellow health card, issued by the government of Quebec. That card entitles her to free medical care at any of the 158 CLSCs in the province or from any doctor or hospital she chooses.

The CLSCs in Quebec, as well as similar community health centers in other provinces, represent an attempt at integrating medical care and social services within the framework of Canada's universal health-care system.

CLSCs help community residents find housing or day care for elderly or sick parents. Some offer smoking-cessation clinics. At others, elderly residents from the surrounding community can come by for a hot lunch at noon or for flu shots. A few CLSCs function as mini-hospitals where patients are admitted and kept overnight for observation and treatment.

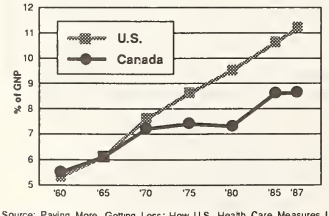
"The CLSC is an example of how policy is moving toward improving the overall health of the population," says Dr. Michael Rachlis, a Toronto physician who has studied his country's health system.

How the system evolved

Twenty-five years ago, just before Canada began phasing in universal insurance for medical services, the U.S. and Canadian health-care systems were on parallel tracks. Both

THE ROAD NOT TAKEN

Canada and the U.S. were spending about the same percentage of their Gross National Products on health care in 1965, just before Canada established its publicly funded insurance system for medical services. Since then, the U.S., which has retained private insurance, has spent a greater portion of GNP on health care.



Source: Paying More, Getting Less: How U.S. Health Care Measures Up, National Health Care Campaign, 1968.

countries were spending about 6 percent of Gross National Product on health care. By 1987, as health-care costs increased throughout the industrialized world, Canadians were spending 8.6 percent, while Americans were spending 11.2 percent.

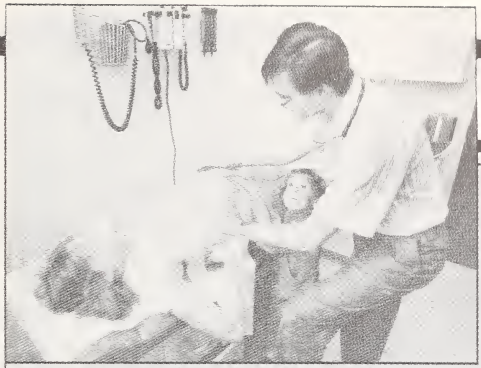
But by then, the two countries were already on very different tracks. In 1966, Canada passed its Medical Care Act, entitling all residents to medical care funded through the tax system. (Free hospital care had been established in 1957.) About the same time in the U.S., the president of the American Medical Association declared that health care was a privilege, not a right—an issue still not fully resolved in the U.S. today.

No private insurance

Canada outlawed private insurance for any services covered by its universal programs. Insurance companies there can sell health policies only to pay for uncovered services, such as private rooms in hospitals, medical expenses incurred in foreign countries, and dental care. When Canadians go to a hospital or see a doctor, they simply show their medical card, issued by the provincial government. The doctor then bills the government and is reimbursed according to fee schedules negotiated earlier. (Hospitals receive an annual budget that covers virtually all patient costs. They are paid one-twelfth of their budget each month.)

Since the billing forms used by doctors are standardized and only the government pays the bills, processing costs are low and providers receive payment in about 30 days. Patients don't have to cope with the deductibles, coinsurance, coinsurance maximums, or out-of-pocket expenses that are part of virtually every American health-insurance policy. Nor do they have to fill out complicated forms. There are no user fees, and doctors cannot "balance bill"—that is, charge more than the negotiated fee. (In the U.S., doctors can bill patients for more than the insurance company's allowable charge.)

Canada's program covers most medical services. However, eyeglasses, prescription drugs for people under 65, out-of-hospital dental care for adults, and cosmetic surgery are usually not covered in most provinces. Some provincial governments also pay for a few nonphysician services, such as physiotherapy, podiatry, and chiropractic treatments.



Photos: CYNTHIA JOHNSON

Prenatal care At a clinic near downtown Montreal, Dr. Stephen DiTommaso examines Sandra Gail Dalgleish while her son Antoine watches. Pregnant women are closely monitored at Canadian clinics and offered services ranging from nutritional counseling to home visits after their babies are born.

Fee-for-service doctors

Although Canada replaced private insurance policies with a public-insurance system, it retained fee-for-service medicine; that is, most doctors receive fees for the services they perform, rather than a salary. Today physicians' incomes are among the highest in Canada—four to five times higher than the average industrial wage. (In the U.S., the average physician in private practice earns five to six times the average industrial wage.)

Each year, medical associations and the provincial governments negotiate an overall increase in the fee schedule. The associations then allocate the increases among various specialties and services.

The negotiated fees, however, tend to be lower than in the U.S. (where doctors also care for patients who can't pay). In Quebec, for instance, medical groups have negotiated a fee of $217 for doctors who perform cesarean sections (they receive $87 more if there are complications and $109 more if the delivery is at night or on the weekend). They receive a fee of $174 for performing an appendectomy. (Here and elsewhere in this report, all Canadian figures are given in U.S. dollars.) In the U.S., the average physician fee for delivering a baby by cesarean is $1222, and the surgeon's fee for performing an appendectomy averages $846.

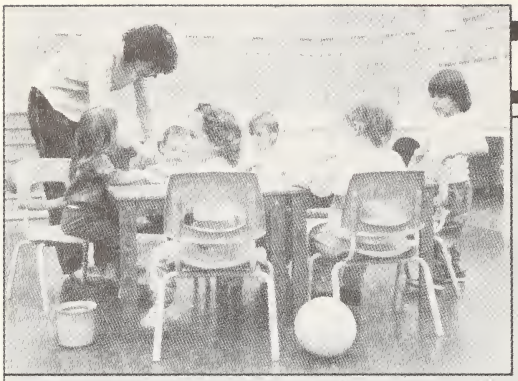
The cost of malpractice insurance in the U.S. is higher than in Canada, and U.S. doctors maintain they must practice defensive medicine to avoid malpractice suits. Nevertheless, the money spent on malpractice premiums still accounts for only a tiny fraction of the differences in cost between the two health-care systems, according to Dr. David Himmelstein of Physicians for a National Health Program.

Compared with the U.S., Canada spends much less on health care, but its system is still the second most expensive in the world, a statistic some trace to an oversupply of doctors who bill for too many services and to overutilization of medical services by patients. The government gives Canadian doctors considerable autonomy in their practice of medicine. And they have no insurance companies looking over their shoulders as do doctors in the U.S.

Hospital budgets

Hospitals also negotiate their budgets with the provincial ministries of health. Budgets are based on a baseline amount that the hospital spent in 1969. Each year, the ministries grant increases for inflation, for new programs, and for increased activity in the hospital's services.

Because the ministries have tended to hold increases to less than the actual rate of inflation, hospitals



Child's play Pierrette Croteau, a child-care worker at the Montreal clinic, helps toddlers and preschoolers at the facility's day-care center. Each day the center looks after 10 to 20 neighborhood children whose parents drop them off either for half-day or full-day care.

have had to redistribute their funds internally to live within their budgets. Ottawa Civic Hospital, for instance, closed 82 beds in 1989 but was able to serve more people than the previous year by shifting patients to outpatient care and surgical day-care centers, eliminating overnight stays for preadmission testing, and shortening the length of stays. Canadian health-policy planners say that reducing the number of days patients spend in hospitals is vital if the system is to get its costs under control.

In the U.S., hospitals in states without limits on hospital rates can simply raise their daily charges and pass them along to insurance companies that pay the bills for patients who are not on Medicare. Insurers then pass them along to policyholders. (For Medicare patients, the Government pays a fixed amount based on the diagnosis.)

New technology

Provincial governments also control the introduction of expensive new technology like magnetic resonance imaging machines, which take sharp pictures of internal organs, and lithotripters, which crush kidney stones and gallstones with sound waves. A hospital can raise private funds to buy an MRI, but since the money to operate it comes from the government, hospitals generally don't do that. Furthermore, doctors can't bill the government for use of the equipment unless it is authorized.

The introduction of new technology has, therefore, gone more slowly than in the U.S. Critics of the system, mostly doctors and hospitals, contend that as a result, some people are being deprived of state-of-the-art treatment. But other Canadians, including health-policy planners and government officials, say there is a benefit in introducing new technology more slowly. They argue that by waiting for reasonable evidence that new technology really works they can make a more informed decision about whether to commit scarce resources to it.

In the U.S., when a new machine comes on the market, its use tends to spread rapidly throughout the medical community—often before there has been time to assess the technology's effectiveness. Once a hospital or a group of doctors buys a new machine, the incentive to use it to recoup the investment exists side by side with the need to use it to improve medical care. That inevitably drives up health-care costs.

No Canadian who is acutely ill is denied prompt medical care. If patients need emergency care and the local hospital has no facilities or equipment to provide it, they are transported to the nearest hospital that does. If necessary services are available only in another province, or in the U.S., the patient goes there, and his or her provincial government pays the entire bill.

The slower implementation of technology sometimes means waiting lists for some procedures, however. A person complaining of headaches doesn't immediately receive a CAT scan and may have to wait several weeks for one. But if doctors suspect the person has a life-threatening ailment such as a brain tumor, a CAT scan will be done right away. The same is true of such costly procedures as coronary-artery bypass surgery.

"None of my patients has ever suffered or been deprived of medical care because of this system," says Dr. Philip Berger, a physician who treats AIDS patients in downtown Toronto. "I treat the poorest and the sickest, and they get everything they need." Even the costly drug AZT is supplied free to AIDS patients by the Ontario government.

Who pays the bill?

The Canadian federal government pays part of the health bill for each province. It pays more of the cost for poorer provinces and less for wealthier ones. The provinces themselves fund the rest of their health-care budgets, which usually account for about one-third of their total annual spending.

At both the federal and provincial level, the money to pay for health care is raised through a combination of personal income taxes; corporate taxes; excise taxes on gasoline, tobacco, and alcohol; and lottery profits.

In Alberta and British Columbia, residents also pay a special insurance premium earmarked for health care. In Alberta, a family of any size pays $552 a year; a single person pays $276. Ontario did away with insurance premiums earlier this year and replaced them with an employer health tax. In Ontario, employers with a payroll greater than $347,826 (U.S.) would pay a rate of 1.95 percent. Employers with smaller payrolls pay less. (Quebec and Manitoba levy a similar tax.) Unlike U.S. payroll taxes, the employee does not pay a matching amount.

A Canadian with a taxable income of $26,086 (U.S.) living in Ontario would pay about $7184 a year in Federal and provincial taxes. Of that, roughly $1340, or about 19 percent, goes to fund health care.

In the U.S., a person with $26,086

A place for the elderly The Montreal center feeds about 100 elderly men and women from the surrounding community each noon. The cost of lunch is nominal—the U.S. equivalent of $2.39. The 158 clinics across the province of Quebec tailor their programs to the needs of the communities they serve.

in taxable income would pay $4776 in Federal income taxes and perhaps another $1304 in state taxes, bringing his or her total income tax to about $6080. None of that money would pay for his or her health care. The person would also pay Social Security taxes, of which about $378 would go to fund Medicare.

The American (or his or her employer) would pay for his or her medical care through private insurance, that typically costs $1500 to $2000 a year. In addition, he or she would have to pay out of pocket the deductibles, coinsurance, and other expenses not covered by the insurance policy. Together, those out-of-pocket costs can easily run between $500 and $1000 per year.

Looking ahead

There's virtually no debate in Canada about whether there should be a publicly funded insurance system or whether all people should have access to health care. There is plenty of debate, however, about whether the dollars the country spends on health care are spent in the right place.

Like other industrialized countries, Canada is also experimenting with ways to control costs. In Quebec, for example, there are caps on doctors' incomes. When a general practitioner's gross quarterly income (before taxes and practice expenses) reaches the U.S. equivalent of $37,102, the government will pay him or her only 25 percent of the usual fee for the rest of the quarter. In effect, then, Quebec has put a damper on the ability of general practitioners to gross much more than $148,000 a year. (In the U.S., the typical general practitioner earns about $216,900 before taxes and practice expenses. But high practice expenses, including the cost of dealing with the fragmented private and public insurance systems and the cost of malpractice insurance, reduced that to a mean net income of about $95,000 in 1988.)

In Canada, as elsewhere, doctors and the medical establishment have been vocal in demanding more resources. The community health centers are controversial, for example, because traditional medical practitioners see them as diverting health-care dollars from new equipment, more operating rooms, and larger fees.

Most Canadians like their health-care system, and would dispute the American Medical Association ad in U.S. magazines last year that characterized their system (without actually naming it) as "underfinanced, overextended, and ill-equipped."

Dr. Eugene Vayda, a U.S. and Canadian citizen who is a professor of medicine at the University of Toronto, has practiced under both the Canadian and U.S. health-care systems. "It's a pleasure to practice in a system where everyone has the same buying power," he says. "It allows you to focus on the patients and their needs. The Canadian system is so much better than the U.S., you can't even speak of them in the same breath." ■

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RO102

The CHAIRMAN. Dr. Nelson, we are delighted to have you here today, and we look forward to your testimony.

Dr. NELSON. Thank you, Senator.

The American Medical Association believes that every person should have access to essential health care. As a practicing doctor of internal medicine in Salt Lake City, UT, the immediate past president of the AMA, and as a representative of organized medicine, I applaud your efforts on behalf of the uninsured, particularly those working Americans who lack basic health coverage.

As a practitioner, of course, I have the dilemma of my patients particularly remember one who came to see me just before I came here, a woman who with her husband operates a small family restaurant. She has Addison's disease. The insurance network that the small, family-owned business was part of failed, and she is uninsurable. She asked me what she could do. They could not find any kind of insurance. The cost of my office calls isn't the problem; I would waive those if need be. But she and her husband are properly terrified at the possibility of her ending up with an illness such as Addison's disease and asthma, which she has, in the hospital, without any kind of coverage. So the plight, as we have heard this morning, is dramatic.

The burden of lack of coverage is borne by everyone. Every other member of society shoulders those side effects, such as cost-shifting to the private and public payers, and providers also absorb a certain amount of those losses, particularly in rural or urban areas where there are high numbers of uninsured.

As I said, the AMA believes that every person should have access to essential health care. Our current health system misses this goal. The system must be improved. Society is demanding this kind of action.

A recent poll conducted by Lou Harris and Associates showed that although the majority of Americans are very satisfied with their physicians and their access to care, they are critical of the health care system as a whole. And I might add that the medical profession itself is critical of the health care system as a whole.

Organized medicine is committed to finding a solution for this problem, and we have been working to that end for many years. Our efforts have been intensified in the last year, as demonstrated by the release in early 1990 of "Health Access America", the AMA's proposal for reform of the health care system. Our proposal would provide universal access to essential health care.

We applaud you, Mr. Chairman and this committee, for your longstanding leadership in addressing the problems of the uninsured, and we urge you to continue these efforts in the 102nd Congress. And in undertaking this endeavor, we ask that you consider the following elements which are essential to any viable solution.

First, the tremendous successes of our current system must be acknowledge. Our health system serves the vast majority of America. Approximately 87 percent of all Americans enjoy access to health services. And in addition, our system provides the most sophisticated and effective health care in the world.

A key element of our success has been our reliance on the private sector and the freedom of choice principle that Americans cherish. We believe that the existing public/private partnership in

health care must be maintained to ensure that these fundamental strengths of our system survive and prosper.

Second, we like you, Mr. Chairman, believe that the optimal way to expand access to the over 20 million employed but uninsured is to require employment-based health insurance. Health Access America calls for a phased-in requirement that employers provide coverage to all full-time employees and their dependents. Cognizant that this requirement could burden business, Health Access America calls for a moderate cost/minimum benefit package and a serious of contemporaneous financial incentives to assist employers in providing health coverage. These provisions are detailed in my written testimony.

Third, we believe that this Nation must address the issue of long-term care. In line with our views on health coverage, we believe that long-term care coverage should be provided primarily by the private sector but with the government acting as a catalyst to stimulate new markets for private coverage and as a guarantor for individuals unable to help themselves.

In closing, we recognize the frustration that exists among individuals, institutions, government, business and labor with perceived problems in our health care system. Some are so frustrated that they want to scrap the entire system and import foreign systems into the U.S. We think that would be la mistake. It would be a mistake because the current system has so many attributes which society is unwilling to relinquish. These attributes must be retained as the backbone of our system while other components are strengthened to meet the needs of society more fully.

Collaborative solutions that recognize the unique needs of each sector and America as a whole must be explored. The American Medical Association has put forth a proposal that attempts in good faith to meet the concerns of various sectors. We believe that it provides a firm foundation for national discussion. We hope to work with this committee and others to craft the optimal solution.

Mr. Chairman, thank you for the opportunity to testify. I would appreciate perhaps during the question period, if you wish, to be able to comment on the problems of the increasing costs of medical care.

Thank you.

The CHAIRMAN. Thank you.

[The prepared statement of Dr. Nelson follows:]

PREPARED STATEMENT OF ALAN R. NELSON

The American Medical Association believes that every patient should have access to essential health care. As a practicing doctor of internal medicine in Salt Lake City, UT; as the immediate Past President of the AMA; and as a representative of organized medicine, I applaud your efforts on behalf of the uninsured, particularly those working Americans who lack basic health insurance coverage, and thank you for the opportunity to testify about the pressing issue of assuring access to health care for all Americans.

The plight of the uninsured in this country is dramatic. Every day the media recounts facts and figures about the uninsured—those individuals who, in insurance jargort, are "going bare." Those facts and figures bear repeating.

Approximately 33 million Americans are uninsured, and many millions more are under-insured. Of the uninsured, approximately 7 are workers and their dependents. Another 3 percent are considered medically uninsurable because of medical conditions, and the remainder are the nation's poor.

The lack of coverage for this group is borne by every one. Obviously, the uninsured themselves experience these problems most directly. Every other member of society, however, shoulders the devastating economic and societal side effects. These side effects include cost shifting to private and public payers who absorb the costs of uncompensated care. Providers also absorb these losses, often disproportionately based upon their location in rural or urban areas with high concentrations of uninsured.

In addition to cost shifting, the uninsured population contributes disproportionately to the nation's spiraling health care bill. Although the uninsured obtain health care less frequently than others, they are sicker when they finally obtain access, and often present with multi-system complications. Thus, they consume tremendous health resources, frequently through the costly emergency care route. Because they have no access to preventive services and no on-going relationship with a physician, the cycle of acute care intervention continues.

Perhaps the most disturbing side effect of our present system is that it perpetuates a two-tiered structure that provides one level of care for the uninsured, and one level for everyone else. The AMA believes that every patient should have access to essential health care. Our current health care system misses this goal. The system must be improved.

Society is demanding just such action. A recent poll conducted by Lou Harris and Associates, Inc., showed that although the majority of Americans are very satisfied with their physicians and their access to care, they are critical of the health care system as a whole. Business, labor and nearly every other segment of society are crying for relief from the costs and uneven accessibility of the current system.

Organized medicine is committed to finding a solution for this problem, and has been working to that end for many years. Our efforts have intensified in the last year, as demonstrated by the release in early 1990 of "Health Access America," the AMA's proposal for reform of the health care system.

We applaud you, Mr. Chairman, and this Committee for your longstanding leadership in addressing the problem of the uninsured, and urge you to continue these efforts in the 102nd Congress. In undertaking this endeavor, we ask that you consider the following elements, which are essential to any viable solution.

THE CURRENT SYSTEM HAS MANY STRENGTHS

First, the tremendous successes of our current system must be acknowledged. Our health care system serves the vast majority of America; approximately 213 million or 87 percent of all Americans enjoy access to health services through existing public or private insurance. In addition, our system provides the most sophisticated and effective health care in the world. A key element of our success has been our reliance on the private sector and the freedom of choice principle that Americans cherish.

We believe that the existing public/private partnership in health care must be maintained to ensure that the "best" of our system survives and prospers. Other countries' experiences have shown that the fundamental strengths of our health care system—technological superiority, quality, competition and freedom of choice—would not survive in a monolithic, centralized system. All indications are that society is not ready to relinquish these assets.

EMPLOYMENT-BASED COVERAGE

Second, we, like you, Mr. Chairman, believe that the optimal way to expand access to the over 20 million employed but uninsured is to require employment-based health insurance. We support this approach, quite simply, because it has worked so well for so many and for so long. Rather than reinventing the wheel, we advocate retaining and reinforcing this proven element of our current system.

Health Access America calls for a phased-in requirement that employers provide coverage to all full-time employees and their dependents. It would abolish pre-existing condition limitations, and expand COBRA coverage to require employers to pay the same premium share paid prior to termination for up to 4 months.

Cognizant that this requirement could burden business, Health Access America calls for a moderate cost minimum benefit package and a series of contemporaneous financial incentives to assist employers in providing health coverage. These incentives include:

preempt ion of the approximate 700 State benefit mandates, and establishment of a uniform Federal minimum benefit package for mandated coverage;

equalization of tax treatment between employers and the self-employed by making permanent and expanding from 25 percent to 100 percent the current deduction allowed the latter group for health premiums;

establishment of tax incentives and other protections for new and small businesses;

establishment of Federal incentives for States to develop private, nonprofit risk pools, that would provide coverage to the uninsurable population and others without access to group coverage; and

amendment of ERISA to allow States to require self-insured plans to participate in the risk pools.

LONG-TERM CARE

Third, we believe that this Nation must address the issue of long-term care (LTC). Given our aging population—which, due to medical technology, will live longer than ever before—and the relative lack of LIC insurance purchased to date, LTC is a vital component of a comprehensive solution.

In line with our views on health coverage, we believe that LTC coverage should be provided primarily by the private sector, with the government acting as a catalyst to stimulate new markets for private coverage and as a guarantor for individuals unable to help themselves. Health Access America would broaden LTC financing through tax incentives and an asset protection program, both of which would encourage private sector coverage. Individuals between 100 percent and 200 percent of poverty would receive sliding scale subsidies to purchase LTC insurance, and employment-based LTC coverage would receive the same tax treatment as employment-based health coverage. In addition, tax incentives should be developed to encourage family care-giving.

There are many other elements that we believe are essential to any comprehensive package—such as professional liability reform, Medicare and Medicaid reform and the development of practice parameters—and we have included as an attachment brochures on Health Access America and its accompanying minimum benefit package.

CONCLUSION

In closing, we recognize the frustration that exists among individuals, institutions, government, business and labor with perceived "problems" in our health care system. Some are so frustrated that they want to scrap the entire system and import foreign systems into the United States. We think that would be a mistake.

It would be a mistake because the current system has so many strengths. It provides 87 percent of all Americans with health care coverage. It sets the world standard for excellence in medical technology and quality of care. It incorporates freedom of choice and encourages competition in the health care market. These precious attributes must not be relinquished. Rather, they must be retained as the backbone of our system, while other components are strengthened more fully to meet the needs of society.

Strengthening the system will not be inexpensive or easy. Good health care is not cheap. It is labor and technology intensive. As a nation we must decide how to address the critical issues posed by the aging population and the many illnesses that plague this country.

Blaming physicians, providers, insurers, government, business, labor or patients is not the answer. Collaborative solutions that recognize the unique needs of each sector and America as a whole must be explored. The American Medical Association has put forth a proposal that attempts in good faith to meet the concerns of various sectors. We believe that it provides a firm foundation for national discussion, and we hope to I work with this Committee and others to craft the optimal solution.

Mr. Chairman, thank you for the opportunity to testify. I will be pleased to respond to questions at the appropriate time.

Health Access America

An AMA proposal to improve access to affordable, quality health care

Americans desire access to high quality health care services at affordable prices and a health care system that is easy to understand and use. Improvements to our current system are needed to meet these desires of the American people.

The American health care system is currently under review by two blue-ribbon commissions, several national medical associations, various health policy professionals, as well as by the Administration and by the Congress of the United States. Primarily, this review has been prompted because a large number of Americans lack health insurance coverage. The increasing cost of health insurance for many Americans with coverage, particularly employment-related coverage, also is of major concern, as are increasing costs within the Medicare program.

The physicians of America who are represented through the American Medical Association share the view that improvements need to be made promptly to our health care system, especially by addressing cost issues and the lack of insurance coverage.

Thus, the AMA has developed a proposal to ensure access by every citizen to the benefits of the American health care system. The diversity of those without insurance necessitates a broad-based approach, utilizing both the public and private sectors, to fashion solutions. Many difficult decisions regarding the allocation of society's resources will need to be made to accomplish the goal of extending access to health care to all Americans. This beneficial goal cannot be achieved without substantial cost.

Thus, in many ways, this proposal presents a challenge to society. A basic challenge for society is whether it is willing to pay for access to coverage by all citizens.

Societal priorities will have to be considered. Revenues may have to be transferred from current programs, or new sources of revenue found. Public support for legislation necessary to bring about concrete results will have to be stimulated, and Congress and the Administration will have to take the lead to bring the legislative goals to fruition. Are the goals of this proposal — the continuation and improvement of our health care system — worthy of the costs involved? The AMA believes the answer is an unequivocal yes.

The AMA believes that a national dialogue must take place to address these challenges and critical issues. The problems facing the American health care system cannot be solved by any one organization. A collaborative process should be pursued, working with government and others.

The AMA is committed to the process of debate and negotiation. We are discussing this proposal with other health care organizations and representatives of labor, business, the insurance industry and other interested groups, as well as the government, and we will be developing refinements and modifications as needed. America's physicians, committed to delivering quality care, want to work with government and other decision makers toward positive solutions. We recognize that modifications to our proposal will be necessary and that, primarily due to cost constraints, priorities and phase-in strategies will need to be established in the accomplishment of different elements of the proposal. But the proposal lays out an outline for action — and the time for action is now.

In developing the specific provisions of this proposal, the AMA has taken into consideration what it believes are a number of fundamental principles that should underscore the national discussion on improving the health care system in this country. These fundamental principles are:

- **Improvements to the American health care system should preserve the strengths of our current system.**
- **Affordable coverage for appropriate health care should be available to all Americans, regardless of income.**
- **Particular efforts are needed to assure continued access by the elderly to affordable health care services.**
- **Health care services should be delivered with high quality at appropriate costs.**
- **Patients should be free to determine from whom and the manner in which health care benefits are delivered.**
- **All physicians should be committed to the highest ethical standards in the delivery of care to patients.**

Each of the above principles is restated below, followed by the relevant specific points of the AMA's 16-point proposal which build upon that principle and which are designed to accomplish the goal of expanding access to affordable quality health care to all Americans. The specific 16 points are then summarized at the end of this proposal. Some elements referred to are already in legislative form — such as the Medicare Reform elements, introduced in the Congress as H.R. 2600 by Rep. Charles Rose (Dem. - N.C.). Other elements will form part of a legislative approach calling for development of legislative proposals or support for proposals already developed by others. Some elements of this proposal require further developmental work, which will be proceeding rapidly.

The AMA's Proposal

Improvements to the American health care system should preserve the strengths of our current system.

Our health care system needs improvement, but such improvement needs to be accomplished in a manner that does not jeopardize the access to quality care enjoyed by the vast majority of Americans.

Widespread health care insurance exists — but many are left uninsured

Approximately 213 million or 87 percent of all Americans today have private or public health insurance coverage providing them access to the highest quality of health care services of any country in the world. Employment-related insurance provides coverage for 60 percent of all Americans, with an additional 27 percent of Americans being covered by government programs or individual policies. Unfortunately, the fact remains that for 13 percent, or about 33 million Americans, access is limited or even unavailable because of a lack of public or private health insurance coverage [based on most recent preliminary estimates from the Bureau of the Census].

Most individuals who lack insurance coverage also lack regular contact with a physician. Without insurance, they often delay medical care until they are very sick and have no alternative but to seek treatment in clinics or emergency rooms. This, of course, is not the most desirable way to deliver care. It increases use of the most expensive care, further driving up health care costs. Delaying care can also result in additional discomfort, increased health risks and greater financial impact for the individuals involved.

Broad public satisfaction with health care

National polls demonstrate that the overwhelming majority of Americans are satisfied with their physicians and the health care services they receive. Yet a significant number are not happy with the cost of health care services, nor are they satisfied with a system that allows so many to go without health insurance. It is clear that the system requires improvement. However, efforts to improve the system should not place at risk the access to quality care currently enjoyed by the vast majority of Americans.

Additional strengths

There are a number of other strengths of our current system, including:

- The ability of most patients to choose the physician, hospital, and system of health care delivery they want.
- The widespread availability of new technologies to Americans.
- The freedom to conduct medical and scientific research in the best interests of patients and to individualize the treatment of patients according to the best interests of each patient.
- A superior medical education system, which seeks to attract the best and brightest and which provides a rigorous and comprehensive learning process to assure the public of well-trained physicians.
- An independent medical profession where physicians are able to act as patient advocates rather than as agents of the government, which is concerned mainly about the budget.

The individual patient's freedom of choice to pursue services which meet his or her health care needs, combined with a free and independent medical profession, are firmly based on the American recognition of the importance of the individual and are cornerstones for our strong American health care system. For the most part, unless the patient selects a delivery system with limited choice, our system does not restrict where or from whom the patient can seek medical services. Unlike other types of health care systems, our system does not place arbitrary limitations or overall spending caps on medical services. All of this is not to say there is no proper role for the government.

Government's role should be: (1) to encourage the private sector to provide health care coverage for the most people possible; (2) to assist the private sector to deliver the highest quality of care for the most reasonable cost; and (3) to provide financial assistance for those Americans who otherwise lack health care coverage. Clearly, to address the access problems existing today, government programs of assistance must be expanded and properly targeted. However, it would be just as clearly counterproductive if government were to extend its efforts to "fix" aspects of the system which are not broken and, in fact, are operating well.

Despite some major problems, our health care system is strong. Never before has the lifesaving medical care and technology found in our system been able to do so much for so many to improve and save lives. Despite this overall success, however, the American Medical Association is deeply committed, along with many other groups in this country, to finding solutions to the problems that do exist. We must find ways to extend needed health insurance coverage to those who lack it. We must also develop better methods to control inappropriate rising costs.

Affordable coverage for appropriate health care costs should be available to all Americans, regardless of income.

All Americans should be assured of affordable coverage of their appropriate health care costs, regardless of their income, through private insurance and through partially or fully government-financed programs for those of low income.

In order to extend coverage to those who are currently uninsured, it is helpful to understand in brief who the uninsured are. It is working Americans and their families who lack health insurance coverage that make up the large majority of the uninsured. About 24 million of the 33 million uninsured persons are workers and their families. For the most part, the remaining uninsured are unemployed persons and their families who are below the federally established poverty level but are not covered by Medicaid. Medicaid actually only covers about 40 percent of those in poverty. An additional category of the uninsured includes persons at various income levels, some of whom are employed and some of whom are not, who are considered by insurance companies as "medically uninsurable" because of health conditions. Recent estimates indicate there are about three million persons in this category.

To accomplish the extension of access to insurance coverage to those without it, several specific actions are needed:

Point 1

Effect major *Medicaid* reform to provide uniform adequate benefits to all persons below the poverty level. The AMA Medicaid Reform proposal would set new national requirements to assure that in all states persons below poverty income levels are eligible for and receive a

uniform set of adequate benefits, so that no poor person is left without access to needed health care. The AMA believes strongly that federal and state governments must assure access to and funding for medical care for persons with incomes below the poverty level.

The federal poverty level should be adjusted by a state cost-of-living modifier to assure that Medicaid eligibility truly reflects the economic realities in the various states. Income status should be the only eligibility criterion; other existing categorical requirements should be repealed. At the same time, using one national formula by which eligibility will be determined in the various states will eliminate state discretion in setting the economic level of eligibility. This will avoid perpetuating the widespread inequities existing across state boundaries in the Medicaid program today.

Medicaid benefits need to assure provision of all medically necessary physician and hospital services — and should not differ across state lines. Because of the impoverished status of Medicaid beneficiaries, added coverage for prescription drugs, rehabilitative services, and emergency services must be provided. Because unrealistically low reimbursement levels reduce access, Medicaid reimbursement levels should be increased to the Medicare level.

Recognizing the substantial costs of Medicaid expansion, some phased-in approach probably will be necessary. One initial approach would include: expanding Medicaid coverage for women and children by requiring a phased-in coverage for pregnant women and children; phasing in a requirement that Medicaid eligibility shall equal 100 percent of the poverty level (state adjusted); and creating a basic national level of Medicaid benefits that must be covered, including necessary inpatient and outpatient hospital and emergency services; rural health clinic and other laboratory and x-ray services; home health services; early and periodic screening, diagnosis, and treatment for individuals under 21; family planning; physician services; prescription drugs; and rehabilitative services.

This AMA uniform benefit package consists of the presently required services plus prescription drugs, rehabilitative services, and emergency services. States, solely at their own expense, could cover additional benefits beyond the basic national level.

There is widespread support for needed Medicaid reforms, including that evidenced by the report of the Health Policy Agenda for the American People (HPA), a broad-based group of organizations representing consumers, business, labor, government, health care professionals, hospitals and insurance companies.

Point 2

Require *employer provision of health insurance* for all full-time employees and their families, with tax help to employers. About 24 million of the 33 million uninsured are employed individuals and their families. Tax incentives must be provided and risk pools created so that new and small businesses can afford the cost of such coverage. At first only larger businesses should be subject to this requirement.

To make the transition manageable for all businesses, the program should be phased in over several years. Additional elements in a legislative program to bring about required employer coverage include:

a. Preempt state-mandated benefit laws for employer health benefit plans to assist small businesses to afford a basic program. Such plans would be required to meet minimum standards of coverage, including basic hospital, physician, diagnostic, prenatal and well-baby care, with reasonable annual limits on employees' incurred expenses for premiums, co-insurance and deductibles.

b. Amend the Internal Revenue Code or ERISA to allow states to require self-insured employers to participate in private, not-for-profit uninsured and uninsurable risk pools established pursuant to state law.

c. Establish a Federal incentive program for states to enact legislation to set up private, not-for-profit health benefit pools (including uninsurable, uninsured and small business).

d. Require such pools to offer to small businesses (less than 25 employees) access to basic benefits policy at group rates.

e. Make permanent the temporary 25 percent income-tax deduction for premiums for health benefits plans for the self-employed. Expand deduction to 100 percent of premium payment for self-employed and others who must pay 100 percent of a health benefit premium.

f. Expand COBRA continuation coverage to require employers to pay the same share of an employee health benefit premium that was paid by the employer, prior to termination, for up to four months after the qualifying event.

g. Require employers to offer an enrollment period for employees who lose coverage because a spouse or other family member lost coverage due to change of employment.

h. Eliminate provisions excluding pre-existing conditions from employee health benefit plans.

Because of the particular importance of the relationship of a basic benefits package to the affordability of required insurance, the AMA is making additional efforts to construct a package that is affordable. It is the essential basic benefits in any health insurance program which impact most on saving lives and improving the quality of life.

Point 3

Create state-level risk pools in all states to make available coverage for the medically uninsurable, for whom access to coverage is not available, and for others for whom individual health insurance policies are too expensive and group coverage is not available.

A state risk pool is a legislatively created insurance program that can be funded in a variety of ways including state tax revenues or insurance company contributions. Risk pools help assure that no American would be unable to obtain affordable health insurance because of a health condition. Small employers should have access to such risk pools so that they could acquire coverage for their employees at affordable rates if it was unavailable for a better price in the private market. Rates should be set at standard group rates. Premium assistance from the state would be provided for those persons not covered through employment and who were between 100 percent and 150 percent of the poverty level. (Only about 15 states currently have risk pools designed to make coverage available to the medically uninsurable.)

Elements of a phased-in legislative approach which can accomplish extension of access to the medically uninsurable and for those otherwise unable to obtain coverage include:

a. Requiring, as a condition of federal tax deduction, that all payors for employee health benefits (payment of premium, or direct payment for services by self-insured plan) must participate in a private not-for-profit risk pool established pursuant to state law. The pool would provide subsidized coverage for those who have been denied coverage or have lost coverage because of a medical condition and underwriting rules.
b. Allowing a 100 percent tax deduction of premium payment for individuals who purchase insurance coverage through the pool.

Particular efforts are needed to assure continued access by the elderly to affordable health care services.

To assure continued access by the elderly to affordable health care services, two major actions are needed:

Point 4

Enact Medicare reform to avoid the future financial bankruptcy of the program by creating an actuarially sound prefunded program to assure senior citizens continued access to quality health care. Today four workers' tax contributions support a single Medicare beneficiary. As our population ages, there will be only two workers paying taxes to support each beneficiary by the middle of the next century. A shrinking worker base means substantially higher premiums in the years to come. Without further support, the system will collapse. This reform measure would include a new approach to catastrophic benefits. The program would be funded through individual and employer tax contributions during working years. There would be no program tax on senior citizens and all persons reaching eligibility age would be entitled to a voucher for purchase in the private sector of a comprehensive health insurance policy meeting federal standards. Senior citizens would retain freedom to choose their system of delivery of care (e.g., fee-for-service, HMO, PPO). The creation of an enhanced trust fund beyond immediate payout needs (prefunding) would create investment income and thus end up costing taxpayers much less than continuation of the current system.

The reform elements noted above are in legislative form, introduced in the Congress as H.R. 2600 by Rep. Charles Rose (Dem.-N.C.).

Point 5

Expand *long-term care* financing through expansion of private sector coverage encouraged by tax incentives and an asset protection program, and provide Medicaid coverage for those below poverty. The "asset protection" approach in essence means that individuals who purchase long-term care insurance would be able to protect designated assets up to the dollar value of the insurance benefits from being included in any eligibility determination for Medicaid coverage for long-term care. This kind of program has been introduced in the Congress by Rep. Barbara Kennelly (Dem.-Conn.), as H.R. 4631. Sliding scale subsidies should be provided for the purchase of long-term care insurance for individuals with incomes between 100 percent and 200 percent of poverty level. Employer-provided long-term care insurance should be treated in the same tax fashion as health insurance coverage. A tax deduction or credit should be created to encourage family care giving.

A phased-in legislative approach to accomplish the above elements would call for:

a. Amending the Internal Revenue Code to allow businesses and individuals to treat payment for long-term care insurance policies in the same manner as health benefit plans are now treated.

b. Allowing individuals to deduct for income tax purposes 100 percent of the cost of long-term care insurance premiums without meeting the 7 percent floor for health costs or the 2 percent for miscellaneous deductions.

c. Amending the tax code to allow for penalty-free and tax-free withdrawals from individual retirement accounts (IRAs) for purchase of long-term care insurance policies.

d. Amending Medicaid to allow for an asset protection program so that resource eligibility requirements are adjusted to allow an individual to retain assets up to the amount that private sector insurance pays on his or her behalf for long-term care.

Health care services should be delivered with high quality at appropriate costs.

Inappropriate costs include costs for defensive medicine, excessive administrative costs which include unnecessarily complicated hurdles for patients to receive care and benefits and interfere with the doctor-patient relationship, and costs brought about by delivery of services which are outside of professionally developed practice parameters and which are not justified after appropriate peer review.

To address the above issues, certain specific actions are needed:

Point 6

Reduce health care costs through professional liability reform to reduce the inappropriate cost of such insurance and defensive medicine. Defensive medicine, the ordering of tests and procedures which might not otherwise be ordered but for liability concerns, drives up the cost of medical services. It has been estimated that liability insurance premiums and defensive medicine add about 15 percent to the average physician's bill. In addition, the AMA has developed legislative reforms and has also developed a pilot program for administrative adjudication of liability claims which is designed to lower the costs of liability insurance while preserving the rights of injured patients. Elements of a legislative approach include:

a. Support federal funding to states to demonstrate alternative dispute resolution systems for medical professional liability cases.

b. Adopt federal legislation that would establish the following selected tort reforms:
   —limitations of $250,000 or lower on recovery of noneconomic damages
   —the mandatory offset of collateral sources (e.g., health insurance and disability benefits) of plaintiff compensation
   —decreasing sliding scale regulation for attorney contingency fees
   —periodic payment for future awards of damages
   —limiting the period for tolling statutes of limitations for minors
   —requiring a certificate of merit as a prelude to filing medical liability cases
   —adoption of basic medical expert witness criteria

Such legislation should override conflicting state laws.

Point 7

Develop professional practice parameters to help assure that only high quality appropriate medical services are provided, thus impacting favorably on the quality and cost of medical care. Such parameters are professionally developed strategies for patient care developed to assist physicians in clinical decision making.

Practice parameters include guidelines, standards and other patient care strategies. Guidelines are recommendations for patient care, which may identify a particular care strategy or a range of care strategies. Standards are generally accepted principles for patient care. Practice parameters may outline a range of appropriate tests and procedures for management of a given clinical condition or may identify a range of clinical conditions for which a given procedure or treatment may be appropriate. It remains the physician's responsibility to choose what is most appropriate for the individual patient.

The primary benefit of parameters is appropriate patient care. Secondary advantages include improved use of resources, reduced liability, and better review criteria. The AMA, in conjunction with national specialty societies, is currently working diligently to facilitate the development of practice parameters, as part of its long-standing efforts to foster high quality care and appropriate utilization.

To accomplish the above goals, legislative support is needed on a continuing basis for adequate appropriations for health care assessment research and professionally developed practice parameters. One significant step in this direction has been taken in legislation enacted in 1989 (P.L. 101-239). Efforts will also seek adoption by HHS, quality assurance programs and utilization review organizations of parameters developed by professional organizations.

Point 8

Alter the tax treatment of employee health care benefits to reward people for making economical health care insurance choices. This reduces the tendency to overinsure which occurs when an excessive number of ordinary, routine and highly predictable health services are covered by insurance. The AMA supports two tax reforms to reduce incentives to overinsure. The first would place a limit on the amount of the employer-provided health insurance that is tax-exempt to the employee. The second would provide tax-exempt rebates to employees who select health insurance plans with premiums less than their employer's contribution to more expensive plans. Such plans would still be required to contain coverage for basic benefits.

Point 9

Encourage cost-conscious decisions by patients, for example, through insurance companies, employers and government programs providing patients more information, prior to service, of the amount insurance or the program will cover.

The enactment in Congress of the resource-based relative value system (RBRVS) for physician payment under Medicare, which was largely supported by AMA, ultimately should help to provide patients with information ahead of time as to what Medicare will pay for a service. This system will also create a more rational basis of physician payment under the Medicare program.

Point 10

Seek innovation in insurance underwriting, including new approaches to creating larger risk spreading groups and reinsurance.

Point 11

Urge expanded federal support for medical education, research and the National Institutes of Health (NIH), to help bring about continuing medical breakthroughs which historically have resulted in many lifesaving discoveries. The American people have benefited greatly from scientific discoveries and technological developments derived from our nation's past support for medical research. Cost-saving as well as lifesaving medical advances made in our country have improved both the quality and duration of life for countless persons both in our own nation and around the globe. We must continue to strongly support such medical research to remain on the leading edge of advancing the state of medical knowledge.

Point 12

Encourage health promotion and disease prevention. Both physicians and patients need to be encouraged to become more active participants in health promotion and disease prevention, including healthier lifestyles. Such activities favorably affect not only the extent and quality of life but also significantly reduce the cost of care. For example, one recent estimate indicates that 35 percent of all hospitalized patients are there due to an alcohol or drug abuse problem. Health-related problems due to other life-style choices, such as smoking, have been widely documented in recent years. Recent estimates by the Centers for Disease Control's Office of Smoking and Health indicate that 390,000 Americans die each year from tobacco-related illness and that the direct health care dollar costs related to such illness is about $22 billion per year. The AMA has been very active and continues to promote programs to eliminate smoking, discourage alcohol and drug abuse, reduce cholesterol, encourage better adolescent health, and other similar programs which are all aimed at improving health and reducing costs of health care.

Point 13

Amend ERISA or the federal tax code so that the same standards and requirements apply to self-insured (ERISA) plans that apply to state-regulated health insurance policies. Currently, employers who self-insure the health care of their employees are exempt from most state requirements that apply to commercial and Blue Cross/Blue Shield insurance policies. This "unequal playing field" removes the self-insured plans from equitable participation in state risk pools, leaving many people without access to affordable health insurance, including small employers. The amendment called for regarding ERISA would not mean that self-insured plans would be subject to state-mandated benefits, since another provision of this proposal calls for a repeal or override of such mandates.

Patients should be free to determine from whom and the manner in which health care benefits are delivered.

Patients should remain free to choose their physician and health care delivery system (e.g., indemnity, HMO, PPO). The individual patient's freedom of choice to pursue his or her health care needs combined with a free and independent medical profession are based on the American recognition of the importance of the individual and are the cornerstones for our strong American health care system.

Several particular actions are needed in pursuit of these goals:

Point 14

Repeal or override state-mandated benefit laws, to help reduce the cost of health insurance, while assuring through legislation that adequate benefits are provided in all insurance, including self-insurance programs. Individuals should be free to choose, at their own cost, additional coverages if desired but such coverages should not be mandated as part of all policies.

Currently, health insurance policies must comply with a myriad of mandated benefit laws in the various states — over 700 such mandates nationwide according to the Health Insurance Association of America (HIAA). The HIAA estimates that, but for such mandates, 16 percent of the small firms that do not offer health insurance would do so and that 51 percent of the firms that converted to self-insurance between 1981 and 1984 would not have done so.

Point 15

Seek reductions in the administrative costs of health care delivery and the *excessive and complicated paperwork nightmare* faced by patients and their families who seek to obtain benefits. There has developed in the last several years a burgeoning multiplicity of unrestrained insurance conditions and paperwork requirements. The frustration of physicians in dealing with the differing managed care requirements of multiple insurance companies, self-insureds, and government programs results in increased costs and interference with the physician-patient relationship.

All physicians should be committed to the highest ethical standards in the delivery of care to patients.

Point 16

Encourage physicians to practice in accordance with the highest ethical standards and to provide voluntary care. In times of strain upon the health care delivery system, where physicians are called upon to deal with multiple competing pressures — particularly from insurance carriers and the government — it is well to note that the AMA will continue its efforts to encourage all physicians to:

- Treat their patients as individuals.
- Use their best professional judgment in every case.
- Inform their patients of the benefits, risks and estimated costs of treatment.
- Treat their patients with courtesy, dignity, respect, compassion and timely attention to their medical needs.

The AMA will also continue its long-standing efforts to encourage physicians to provide health care services without charge or at reduced rates for persons who are without insurance and cannot afford health services. Numerous medical society sponsored efforts to provide free or reduced-fee care to the needy are in place in many but not all areas of the nation. However, these efforts are not enough to provide such care to all of those in need. Recent AMA surveys indicate physicians provide an average of 150 hours of care annually free of charge — coming close to $11 billion of uncharged care. Such efforts will clearly need to continue for the foreseeable future.

Summary of AMA Proposal

The elements of the AMA proposed plan may be summarized in the following 16 points:

1. Increase access by enacting major *Medicaid Reform.*
2. Increase access by requiring *employer provision of health insurance.*
3. Increase access by creating *state-level risk pools in all states.*
4. Maintain access and reduce costs for the elderly by enacting *Medicare Reform.*
5. Increase access and reduce costs for the elderly by enacting necessary legislation to *finance expanded long-term care coverage.*
6. Reduce health care costs through *professional liability reform.*
7. Maintain quality and reduce costs through *development of professional practice parameters.*
8. Reduce health care costs through *altering the tax treatment of employee health care benefits.*
9. Reduce costs by *encouraging cost-conscious decisions by patients.*
10. Reduce costs by seeking *innovation in insurance underwriting.*
11. Maintain quality through expanded *federal support for medical education, research and the National Institutes of Health (NIH).*
12. Maintain quality and reduce costs through *increased health promotion and disease prevention.*
13. Reduce costs and increase access by *amending ERISA or the federal tax code to equalize treatment of self-insured and insurance plans.*
14. Reduce costs and increase access by *repealing or overriding state-mandated benefit laws.*
15. Reduce costs by *reducing administrative costs and paperwork.*
16. Maintain quality and access through *encouraging physicians to practice in accordance with the highest ethical standards and to provide voluntary care.*

Conclusion

Accomplishing the goal of strengthening the American health care system through the elements contained in this AMA proposal will present an enormous challenge to all concerned. For its part, the AMA intends to move forward vigorously on legislative and other fronts. The AMA welcomes and encourages the support of others to help bring about an improved American health care system.

February 1990

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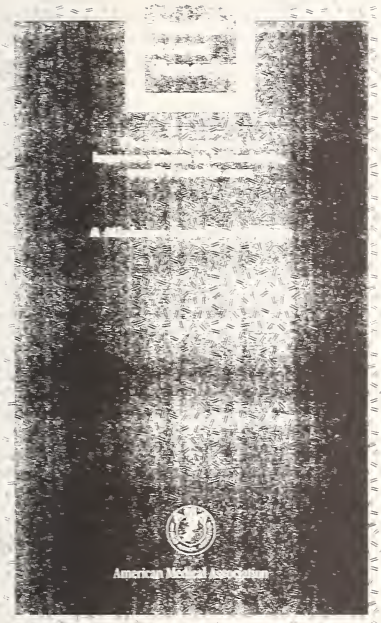

The issue seems clear. Some 33 million American[illegible] insurance coverage, leaving them with limited access [illegible] Health insurance must be extended to cover these uninsured. The issue, yes, yet many decisions lie between the problem [illegible]

Health Access America, the American Medical Association [illegible] provides one blueprint for those decisions. The proposal [illegible] specific public and private sector measures to extend [illegible] Americans.

Health Access America states that employer health [illegible] should be required by federal law. The proposal then [illegible] implementing this requirement, including the use [illegible] benefits package.

Defining minimum benefits

[illegible] package [illegible] minimum coverage. The package presented here [illegible] would be required in an employer [illegible]

This package is designed to be the most good for [illegible] do not have coverage, while balancing cost considera[illegible] features that result in a reduced premium yet provides substantial coverage.

Cost of the package

The AMA minimum benefits package is estimated to cost [illegible] an average of $1,700 a year per employee. This is based [illegible] the employees having family coverage and 40 percent [illegible] coverage. The employer pays 80 percent of the premium.

Nationally, the average employer now spends between $2,100 and $2,[illegible] per employee for health insurance premiums.

To develop the minimum benefits package, AMA staff worked [illegible] the Tillinghast Company, a leading actuarial firm with substantial experience [illegible] pricing employee health benefits.

The AMA minimum benefits package

Maternal and child care

- Pre- and post-natal care
- Pregnancy care including complications
- Delivery
- Immunizations and well-child care up to age 8, using American Academy of Pediatrics guidelines

Physician services

- Medically necessary services provided in inpatient and outpatient settings, up to 20 office visits per person per year
- Diagnostic and therapeutic services
- Medical or surgical treatment of illness or injury
- Diagnostic imaging
- Laboratory services

Dental services

- Limited to repair necessitated by injury to sound teeth or jaw

Outpatient facility services

- Use of emergency room, supplies
- Emergency treatment
- Outpatient facility and diagnostic services, including X-rays, lab tests
- Use of operating room, supplies
- Dialysis care

Inpatient hospital care

- Up to 45 inpatient days per person per year
- Semiprivate room, board
- Nursing services
- Diagnostic services
- Drugs, oxygen, blood, biologicals, supplies, appliances, equipment
- Operating, delivery and recovery room charges
- Intensive, coronary and other medically necessary special types of care
- Dialysis
- Rehabilitation unit charges
- Care for pregnancy and complications
- Other medically necessary ancillary services

Home health services

- Medically necessary services prescribed by physician, up to 240 visits per person per year
- Physician services
- Services of nurses, aides and medical social workers under physician supervision
- Medical supplies, appliances
- Oxygen, blood, biologicals
- Durable medical equipment rental
- Ancillary services

Other

- Ambulance
- Skilled nursing facility, up to 180 days per person per year

Not covered

- Routine physicals, routine screening tests and exams
- Detoxification
- Sterilization, reverse of sterilization
- Artificial insemination, family planning
- Cosmetic surgery
- Obesity treatment, weight loss programs
- Custodial or domiciliary care
- Eyeglasses, hearing aids
- Orthopedic shoes
- Orthodontic appliances
- Hospice
- Outpatient prescription and nonprescription drugs
- Outpatient speech, occupational, physical therapy
- Personal comfort items

Deductibles. The basic deductible is $350 per individual and $750 per family.

There is no deductible on pre-natal and post-natal care of mother and infant, nor for well-child care and immunizations up to age 8.

Co-payments. The insured individual generally pays 20 percent, except as follows:

First $1,000 of services, after deductible	30 percent
Additional services, except as otherwise provided	20 percent
Inpatient room and board	30 percent
Outpatient facility services	30 percent

$25 emergency room co-payment per visit, after deductible

There is no co-payment on pre- and post-natal care of mother and infant, nor for well-child care and immunizations up to age 8.

Out-of-pocket limits. Limits are set at $1,500 per individual and $3,000 per family.

Deductible and co-payment amounts, but not premium payments, go toward meeting out-of-pocket expenses.

Lifetime benefit limit per person is $1 million.

Other. As an optional benefit, employers should be required to offer coverage for unlimited physician office visits and hospital days, at an added cost to the employee selecting this coverage.

Steps to implementation

The AMA Health Access America proposal includes the following additional recommendations regarding employer-based insurance:

- Federal tax incentives must be provided and risk pools created so that new and small businesses can afford the cost of coverage.
- State-mandated benefit laws must be preempted so that small businesses can obtain an affordable minimum benefits package of health insurance for their employees.
- The Internal Revenue Code or ERISA must be amended so states can require self-insured companies to participate in state-operated risk pools. Small businesses and others for whom coverage is not available could use these pools to purchase minimum benefits policies at group rates.
- COBRA insurance continuation coverage must be expanded to require that employers pay the same share of an employee health benefit premium as was paid prior to termination, for up to four months.
- Policy provisions excluding pre-existing conditions from employee health insurance must be eliminated.
- Innovation in insurance underwriting should be pursued, to create larger risk spreading groups and reinsurance mechanisms.

For additional information

The AMA is interested in developing a dialogue with businesses across the country to explain Health Access America and discuss the private sector's role in improving access to health care.

For further information, write Health Access America, American Medical Association, 515 North State Street, Chicago, Illinois 60610.

October 1990

The CHAIRMAN. Ms. Archuleta, we'll be glad to hear from you.

Ms. ARCHULETA. Good morning, and thank you, Mr. Chairman.

I am pleased to have this opportunity to discuss one of the most formidable challenges facing our Nation today—the reform of our health care system.

AARP is committed to improving our health care system so that all Americans, regardless of age, have access to needed care and are protected from burdensome costs. As a Nation, we can no longer ignore the serious State of our health care system.

The cost of health care continues to rise at a substantial rate, consuming more and more of our tax dollars and economy. Thirty-seven million Americans are vulnerable to all but the most modest acute health care problems because they have no health insurance. Millions more are seeing their employee or retiree health coverage cut back. As an example of that, every year I see changes coming about in my retiree benefits.

Medicare costs continue to rise both for beneficiaries and for the Federal Treasury. Employers of all States see significant and growing percentages of their budgets and their profitability eroded by the rising costs of health benefits.

State governments feel the crunch as health care consumes more and more of their budgets.

And virtually all Americans are vulnerable to the devastating costs of long-term care.

The common factor running through all of these failings and gaps in our system is the continuing rise of health care costs. It crosses all age groups and income brackets. Children are left uninsured because dependent coverage was eliminated from their parents' company plan. Older Americans pay higher costs for less comprehensive care. Young adults cannot buy health insurance due to potentially costly health conditions. And couples are struggling to raise families while paying extraordinary amounts for long-term care for their parents.

Countless people have had their lives and dreams shattered by the lack of access to health insurance. Each of us is just as vulnerable.

The piecemeal approach we have taken toward reform does not control costs, and our health care system remains seriously fragmented. Only comprehensive reform will assure access to quality health care, provide protection against the devastating costs of long-term care for Americans of all ages, and allow us to gain control of escalating costs.

That is why AARP has adopted ten principles that establish a framework for achieving health care reform. These principles are included with our written testimony.

We believe that Congress must establish a blueprint, the broad architecture of a reform system that reflects these principles.

Incremental steps may be necessary to move us toward this comprehensive reform, and again in our written testimony, we include some of the specific steps.

Critical to reform is a better public understanding of the nature of the problem, the cost of health care and its pervasive effects on all Americans. Our lack of consensus on the nature of our health care problem has resulted in a piecemeal or bandaid approach to

health care policy. Year after year, we have added levels of complexity to our already fragmented health care system, resulting in perpetual cost-shifting and increasing administrative costs. Until we realize that the cost of health care is a common theme that is a barrier to access for individuals and forces health care expenditures to skyrocket for government, business and insurers, reform will come slowly if at all.

Since 1984, over four out of five Americans have answered yes to the question: Do you think all Americans should have access to the same quality of health care regardless of their ability to pay for it?

In 1989, in a survey conducted by AARP, over three-quarters of Americans said they believed that our system of health care should be completely rebuilt or should undergo fundamental change. Only 15 percent thought our health care system works well. Of those who said changes are needed or we need to completely rebuilt, 65 percent identified cost as the major reason.

The message is clear that the challenge before us is formidable if we are to achieve a solution which commands broad public support.

AARP will continue to increase its public education efforts to develop a better understanding of this crisis and to identify realistic solutions. We urge the Congress and this committee to lay the groundwork by convening public hearings around the country that focus public attention on the tough choices that must be part of the solution.

We must build a consensus on the answers to several important questions such as: What elements of a health care system are most important to Americans? Are we as health care consumers willing to make the tradeoffs that will be necessary to ensure access to all Americans? And are we willing to pay the cost of these benefits?

Resolution of this question is critical to ultimately reform our system.

AARP believes that any financing of health care reform should be broad-based and equitable. Social insurance programs such as Social Security and Medicare enjoy considerable public support because the public understands the simple but essential point that under social insurance, everyone pays in, and everyone is eligible to draw out.

Comprehensive health care reform will only achieve broad support if it is primarily financed through a social insurance structure. We have an obligation to raise these questions. Comprehensive reform will only be possible when the American people understand their common need for protection and their vulnerability and recognize the danger in piecemeal solutions.

We are confident that with your help, we can answer these questions and form clear and strong messages to our elected officials. Health care reform must be addressed by our political parties and their candidates. The 1992 Presidential election will offer an important opportunity to engage in a national debate and help solidify Americans' commitment to health care reform.

Mr. Chairman, I appreciate the opportunity to address your committee today. AARP stands ready to work with you and your colleagues in achieving comprehensive and affordable health care for all Americans.

Thank you.

[The prepared statement of Ms. Archuleta follows:]

Prepared Statement of Lena Archuleta

Good morning. My name is Lena Archuleta. I am a member of the Board of Directors of the American Association of Retired Persons (AARP). I am pleased to have this opportunity to discuss one of the most formidable challenges facing our Nation today making health and long-term care affordable and available to all Americans. AARP is committed to the goal of reforming our health care system so all Americans, regardless of age, have access to needed care and are protected from burdensome costs.

As a nation, we can be proud of our achievements in health care, and we should not continue to allow these achievements to be diminished by our failure to guarantee all citizens access to basic medical and long-term care. Most importantly, we must strive to bring escalating health care costs under control through comprehensive reform. Failing this, we will likely see millions more of our fellow citizens joining the ranks of the uninsured and underinsured.

Undoubtedly, the phenomenal increase in health care costs is the most substantial barrier to access that extends across all age groups and income brackets. Those with and without insurance are at risk: the worker whose children are uninsured because dependent coverage was eliminated from the company's plan; the older American who now pays higher costs for less comprehensive retiree health care; the young adult who cannot buy health insurance due to a potentially costly health condition; the couple struggling to raise a family while faced with the extraordinary expense of long-term care for their parents; and the small business that cannot afford health care coverage for their employees and dependents. There are countless examples of people whose lives and dreams have been shattered by the lack of access to health insurance. Each of us is just as vulnerable.

Comprehensive reform of our health care system must become a national priority if we are to reach our goal of assuring access -to quality care for all our citizens and gain control of escalating health care costs.

AARP has adopted ten principles of health care reform. These principles (included at the end of our written testimony) establish a framework for achieving health care reform. AARP believes that to achieve meaningful health care reform, Congress must establish a blueprint—the broad architecture—of a reformed system that reflects these principles.

Equally important to developing a blueprint for reform is a better public understanding of the nature of the problem—the cost of health care—and its pervasive effects on all Americans. Until the increase in health insurance premiums of workers and their employers, the increase in premiums and deductibles for Medicare beneficiaries, and the cost of care for the uninsured or those needing long-term care are seen as part of a common problem, reform will be slow.

Our lack of consensus on the nature of our health care problem has resulted in a piecemeal or "band-aid" approach toward reform. Year-after-year we have added levels of complexity to our already fragmented health care system, resulting in perpetual cost shifting and increasing administrative costs. As we attempted to control costs in one program, we shifted the burden to another. Efforts to control provider costs have only increased the lack of -uniformity in reimbursement practices between public and private sector programs and further contributed to the problem.

The problems caused by piecemeal solutions are also quite evident in long-term care coverage. All Americans are at risk of needing long-term care, but neither Medicare nor private insurance has sufficiently pooled this risk, leaving Americans of all ages in jeopardy of losing their life savings. In addition, the diversity of demands on the Medicaid program has made it increasingly difficult for that program to carry out its mandate of providing basic health and long-term care services to the Nation's poor.

The lesson is clear: we need to develop a consensus around a comprehensive health care reform plan to adequately reimburse health care providers in order to achieve real cost control. Only when we take this step can we have confidence that all Americans will have access to the quality, affordable health and long-term care that they need.

My testimony examines three issues AARP believes must be addressed to successfully reform our health care system: 1) escalating costs; 2) declining access to basic medical and long-term care; and, 3) ensuring a high quality of care. I will also discuss incremental approaches that can move us toward our goal.

ESCALATING HEALTH CARE COSTS

The escalating cost of health care in America is the most significant problem of our current health delivery system. The uninsured and underinsured, employers, the insurance industry, and government health care programs are all adversely affected by the uninhibited growth in health care costs.

The statistics are staggering despite years of public and private efforts to control costs. Expenditures for health care in the United States totaled $604.1 billion in 1989, an increase of 11.1 percent from the previous year. National health expenditures have grown at faster rates each year since 1986, when the increase was 7.7 percent. These sharp increases have limited access to health care and imposed a heavy burden on individuals, government, and industries.

A few other important statistics on 1989 health care costs are also sobering. For instance:

Health care spending totalled 11.6 percent of the Gross National Product (GNP), more than twice its 1960 share.

Health care expenditures averaged $2,354 per capita, up from $2,124 in 1988.

Americans paid $124.8 billion out-of-pocket for health care, averaging 23.5 percent of total health care expenditures.

Physician expenditures increased nearly 12 percent to $117.6 billion, 19.5 percent of total health spending.

Hospital expenditures increased 10.0 percent from 1988 to 1989, accounting for 38.5 percent of all health spending in the United States. Medicare and Medicaid alone financed more than one-third of the Nation's $233 billion hospital bill in 1989.

Consumer price inflation for all items increased 4.8 percent in 1989, while medical inflation increased 7.7 percent.

For nursing homes, national health expenditures increased 140 percent from 1980 through 1989. Out-of-pocket expenditures accounted for 44 percent of expenditures for nursing home care in 1989, Medicaid contributed 43 percent, and Medicare covered eight percent and private insurance paid for only one percent of the costs. (Note: Previously, Medicare spending accounted for only one to two percent of nursing home expenditures. In 1989 only, however, changes made in the Catastrophic Coverage Act appreciably increased Medicare's share of the nursing home bill.)

An estimated 81 percent of annual out-of-pocket expenses over $2,000 incurred by elderly persons is spent on long-term care. With average annual nursing home costs of $30,000 and home health care costing from $50 to $200 per day, long-term care out-ofpocket costs are often truly catastrophic.

After nursing home costs, the cost of prescription drugs is the second largest out-of-pocket expense for older Americans. The escalating costs of prescription drugs are a growing barrier to effective therapy, particularly among the elderly. In the U.S., people over 65 represent only 12 percent of the population, yet they consume 30 percent of all prescription drugs.

All Americans, however, can be affected by the dramatic increase in drug prices. Between 1980 and 1989, prescription drug prices roes by 128 percent compared with an increase in the overall CPI of about 50 percent. In 1989 alone, when the overall rate of inflation was 4.8 percent, average prescription drug prices roes by 8.7 percent. As drug prices continue to climb, access to affordable drug therapies will shrink. The undesirable result will be higher health care cost from unnecessary hospitalization and other health care expenses.

Employers are also feeling the effects of escalating health care costs. Between 1970 and 1988, employer-provided health care costs more than doubled as a percentage of total compensation. Employers experienced particularly significant cost increases due to mental health and substance abuse benefits.

In addition, Federal health programs increased from 14.1 percent of total Federal expenditures in 1988, to 14.7 percent in 1989. The health share of Federal spending was only 11.7 percent in 1980. As the pressure to reduce the budget deficit increases, cutbacks in health care spending may be viewed as the easy way out. But, we must look beyond the "quick fixes" that will only add to our health care problem in future years and concentrate on comprehensive reform.

All of these statistics reflect the direct costs of health care. We must recognize that in addition to these costs there are significant indirect costs that exact a heavy price on those affected. Take, for instance, a mother who has sacrificed a career to tend to her child who needs long-term care due to a disability or illness. Health care statistics typically do not account for the years of forgone income and benefits that this mother, and millions of others like her, will experience. These costs, however, are very much a part of our current health care system and need to be taken seriously in any discussion of meaningful health care reform.

AARP firmly believes that comprehensive health care reform can not only provide access to basic health and long-term care services for all Americans, but can also allow for more achievable cost containment and address the "hidden" costs I have just mentioned. Uniform methods of provider reimbursement could be established to promote cost containment, encourage efficient service delivery, and compensate providers fairly. In addition, health care spending could be more rational and better managed through more effective planning, budgeting, and resource coordination. By its very nature, comprehensive health care reform will make cost containment achievable, just as the fragmentation and complexity of our current system guarantees its failure.

AARP recognizes that incremental steps may be necessary to move toward a comprehensive health care system that will provide universal access and allow for meaningful cost control. In this regard, AARP strongly supports recent steps to control the costs of the Medicare Part B program. Medicare Part B is among the fastest growing Federal programs. For years, physician costs have increased dramatically, creating higher out-of-pocket costs for beneficiaries. In 1988 alone, physician charges that exceeded Medicare's approved rate resulted in over $2 billion in additional direct costs to beneficiaries.

The Physician Payment Reform package enacted by Congress contains two key provisions intended to bring these costs under control: 1) a volume performance standard to control the rate of increase in physician spending; and 2) a strong framework of beneficiary protection, including a limit on physician balance billing. These two improvements can make a significant difference in the costs associated with Medicare Part B and should be implemented according to the timeline established in 1989 legislation.

Long-term care costs could be better contained if States were required to adopt care management systems to target services and control utilization. In addition, including respite and adult day care in the menu of services available could reduce institutionalization and permit caregivers to pursue productive career-related activities.

AARP also encourages incremental steps that will allow for greater cost control and access to prescription drugs, especially among older Americans. An expansion of the Medicare program to cover outpatient prescription drugs, with reasonable beneficiary cost-sharing provisions, would greatly expand access to needed drug therapies among older Americans. This could help reduce unnecessary hospitalization and other health care expenses caused by the increasing unaffordability of drugs for many older patients. Building towards a comprehensive health care program, cost containment methods should be part of such a program, including reasonable restraints on prices charged by drug manufacturers.

DECLINING ACCESS TO BASIC MEDICAL AND LONG-TERM CARE

Escalating health care costs are linked to the decline in access to health care coverage in America. Approximately 34 million Americans under the age of 65 have no health insurance and millions more have' inadequate insurance protection, including workers. Even though two-thirds of employees receive health insurance from their employers, working people represent more than half of uninsured adults. Even when workers are insured, their dependents may not be. Indeed, the largest decrease in health insurance coverage between 1979 and 1986 occurred in coverage obtained through another family member's employment.

Employees and their dependents of small firms are especially vulnerable. primarily due to the inability of small employers to spread the risk of serious illness over a large workforce, health insurance for their workers is significantly more expensive than it is for larger employers. About one-half of the working uninsured are in firms with fewer than 25 employees.

The lack of comprehensive Federal programs also contributes to the access problem. The Medicare program, for instance, still has significant gaps in coverage and the required copays are more than some elderly can afford. There is no Federal program to cover the costs of long term care forcing many individuals to deplete their life savings and depend on Medicaid. Lack of access to home and community-based services creates incentives to place individuals in nursing homes when other alternatives would be preferable.

The Medicaid program, which was intended to serve as the "safety net" for our nation's low income population, is severely limited. In addition to constant budgetary constraints, a means-tested program does not receive the broad public and political support granted to social insurance programs like Social Security and Medicare. Such welfare-based programs typically place unreasonably restrictive income and

asset eligibility requirements on groups and impede access because of administrative barriers in the application process and the stigma attached to it.

Other problems with the Medicaid program include: (1) exclusion of major population groups from coverage, regardless of income; (2) variations in benefits according to place of residence due to the tremendous differences among State programs; and (3) inadequate reimbursement to health providers, reducing program participation, which further impedes access, and causing providers to shift costs onto insured and private-pay residents.

Comprehensive health care reform could significantly reduce many of the health care access problems associated with our current system by reducing the cost barrier through broad-based, social insurance financing where everyone contributes his or her fair share in return for guaranteed access. In addition, a uniform provider reimbursement scale could be established to help control costs and assure equal access.

AARP believes that individuals of all ages have a right to receive quality health care services when they need them, and that the public, through the Federal and State governments, has the ultimate responsibility to develop a system chat ensures reasonable and equitable access to needed services. All individuals should be assured of a minimum benefit package through either a public or private health coverage plan.

Although comprehensive reform is essential for: ensuring access to health care services for all Americans, incremental steps can and should be taken to move us closer to that goal. Reforming the private health insurance market, especially for small employers, is a critical step in the right direction.

Reforms for the private health insurance market for small employers should focus on making insurance more available. Coverage should not be denied even if one or more of a company's employees is considered to be a "high risk" in terms of his or her potential for incurring substantial medical costs. Further, once insured, termination of coverage should not be allowed for the group or any one individual due to the deterioration of the health of a member or members of the group. Limits on premiums and premium increases as well as deductibles and coinsurance should be established with little variance among similar groups. These reforms would significantly improve access to health care coverage for small employers and their employees and dependents. Federal standards for private long-term care insurance will also help consumers.

AARP also supports expansions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 allowing workers and their dependents continued access to health care coverage for specific periods when access to lower cost group plans or government programs is not available. COBRA expansions that increase access to employer-provided health benefits would allow for more workers and their dependents to take advantage of uninterrupted health care coverage under more circumstances.

AARP also supports the following incremental steps to improve the Medicaid program:

Enabling everyone whose income is at or below the Federal poverty line to be eligible for Medicaid, giving States the option to exceed the minimum standard.

Requiring States to have medically needy programs for people of all ages.

Adjusting Medicaid reimbursement to help ensure adequate access to services.

Increasing the "personal needs allowance" for Medicaid nursing home residents, with annual indexing.

Improving and updating Medicaid data collection.

ENSURING A HIGH QUALITY OF HEALTH CARE

AARP believes that comprehensive health care reform can and should be accomplished without compromising quality. Over thepast decade, policies aimed at controlling costs have contributed to the under and overuse of health care services, increasing our concern about assuring high quality health care.

Countless individuals are forced to forgo treatment because of financial barriers to access. When their health deteriorates and they seek assistance, it is often too-little-too-late and in a setting, such as an emergency room, that is frequently more costly per visit to administer. Research also shows that many individuals receive unnecessary, excessive, or inappropriate services—increasing costs and posing risks to the health of the patients.

Comprehensive health care reform will require a major commitment to achieving and maintaining quality in medicine, as measured by clinical outcome, appropriate-

ness, and effectiveness of care. Clearly there is a need for greater information about clinical outcomes, statistical norms, and effectiveness of treatment.

AARP endorses actions that target and investigate substantial variations in medical practice, including: 1) the monitoring of geographic medical practice variations; 2) supplying all medical providers with information about practice variations; 3) increasing the study of the effectiveness and appropriateness of common medical treatments; and 4) reducing inappropriate and unnecessary use of hospitals. In addition, quality assurance programs, such as peer review and professional licensure, should be strengthened and coordinated.

CONCLUSION

AARP believes that containing health care costs and guaranteeing all Americans access to affordable, quality health and long-term care must be a national priority. We recognize that broad public consensus about the problem and the need to share the risk of health care costs are key ingredients in achieving this goal. In discussing this issue with AARP members nationwide, we have found that continued public education will be essential for building a -consensus on this important issue.

AARP will continue to increase its public education efforts to develop a better understanding of this crisis and find realistic solutions, but we cannot do this alone. Therefore, we call upon the Congress to lay the groundwork by convening public hearings around the country that can explore the scope and complexity of the problem and focus public attention on the tough choices that must be part of the solution. We must build a consensus on the answers to several important questions:

What elements of a health care system are most important to Americans?

Are we, as health care consumers, willing to adjust our patterns of use and coverage, and are we willing to make the trade-offs that will be necessary to ensure access for all Americans?

Are we willing to pay the cost of these benefits, not only in the aggregate, but as individual taxpayers?

This last question is the focal point in the debate over health care reform. AARP believes that any financing of health care reform should be broad-based and equitable. Social insurance programs, like Social Security and Medicare, enjoy considerable public support. Comprehensive health care reform will only achieve broad support if it is primarily financed through a social insurance structure.

We have an obligation to raise these questions with the American people. Comprehensive reform of" our health care system will only be possible when the American people understand the need for protection and recognize the inherent danger involved in continuing a piecemeal approach to a comprehensive problem. We are confident that, with your help, we can answer these questions and form clear and strong messages to our elected officials. Clearly, the 1992 Presidential election will offer an important opportunity to engage in a national debate that can help solidify America's commitment to health care reform.

Mr. Chairman, I appreciate the opportunity to address your Committee today. AARP stands ready to work with you and your colleagues in achieving the goal of comprehensive and affordable health care for all Americans.

PRINCIPLES ON HEALTH CARE REFORM

The American health care system suffers from serious and fundamental problems. Health care costs are increasing at unsustainable rates. Almost 34 million Americans do not have even basic health insurance to protect them from the financial costs of serious illness. Further, this Nation has no system to cover the costs of long-term care, leaving most Americans vulnerable to potentially devasting nursing home and home health care costs. ASTP believes that the United States has the resources to ensure universal access to needed care.

AARP's members are affected, directly and indirectly, by each of these serious problems. To address them, AARP is continuing its work on two related efforts: (1) to reform the current health care system to control costs, improve quality, and guarantee access; and (2) to create a comprehensive system to finance and deliver long-term care services to all Americans (see Chapter 6). While these efforts are closely related, they require different approaches because of the structural differences between the relatively well-developed health care system and the relatively under-developed (and seriously inadequate) long-term care system.

The following principles are designed to guide the Association in its efforts to reform our current health care system. The principles do not address every specific issue or approach relating to health care reform, but they do establish criteria for

evaluating and comparing reform proposals. Over time, as the debate progresses, these principles will assist the Association in the development of more specific and refined positions on comprehensive health system reform.

AARP's advocacy for comprehensive reform does not diminish its support for the incremental improvements to the health care system discussed throughout this chapter. In affirming these principles, however, AARP is stating that the fairest and most effective approach to solving our health care problems lies in implementing comprehensive and universal reform.

PRINCIPLES FOR HEALTH CARE REFORM

All individuals have a right to receive health care services when they need them. The public, through the Federal and State Governments, has the ultimate responsibility to develop a system which ensures reasonable and equitable access to needed health care services for all individuals.

All individuals have a right to reasonable access to health care coverage which provides adequate financial protection against health care costs. The public, through the Federal and State Governments, has the ultimate responsibility to develop a system which ensures universal access to health care coverage for all individuals, including individuals with disabilities or health problems. The health care system should be designed to ensure that all individuals are covered by a public or private health coverage plan. The government should establish a minimum benefit package to which all individuals are entitled.

All individuals have a right to high quality health care. The health care system should collect, analyze, and disseminate information about provider performance, health care outcomes, and the appropriateness and effectiveness of health care services. Quality assurance programs, such as peer review and professional licensure, should be strengthened and coordinated.

All individuals should have a reasonable choice of health care providers. Cost containment efforts should not unreasonably limit choice of providers. Consumers should be provided with sufficient information about health care providers and treatment options to make informed health care decisions.

Financing of the health care system should be equitable, broadly based, and affordable to all individuals. Government, employers, and individuals share the responsibility to participate in health care financing. Our present method of financing health care should be replaced by fairer, more progressive financing approaches. Burdensome cost-sharing requirements (e.g., burdensome deductibles and coinsurance) should be avoided because they disproportionately affect the sick and the poor. The public, through the Federal and State governments, should subsidize the cost of health care coverage for individuals with lower incomes and should fully finance health care coverage for the poor. Any financing method should preserve the dignity of the individual, regardless of his or her income level.

Methods of provider reimbursement should promote cost containment, encourage efficient service delivery, and compensate providers fairly. Health care providers should receive basically the same reimbursement for the same services within a given area, regardless of the payment source. The Government should play a major role in establishing more uniform reimbursement practices and rates for health care providers. Health care providers share in the responsibility to be fiscally prudent.

Health care spending should be more rational and should be managed through more effective planning, budgeting, and resource coordination. The distribution and allocation of health care resources (e.g., capital, technology, and personnel) should encourage innovation, efficiency, and cost effectiveness, and should promote reasonable access to services. Federal and State Governments should play a major role in planning and coordinating the allocation of health care resources.

All individuals have a right to a clean, healthy, and safe environment. The public health system (e.g., water and sewer service, environmental protection, occupational safety, etc.) should be strengthened to ensure the public's health, safety, and well-being. Public health efforts should: (1) increase citizen understanding and awareness of health, environmental and safety issues and problems; (2) improve access to primary and preventive care services, such as maternal and child health care, immunizations, and nutrition counseling; (3) conduct health, environmental, and safety-related research; (4) coordinate the collection and dissemination of information about health, environmental, and safety issues; and (5) assure compliance with health, environmental, and safety standards.

Individuals share a responsibility for safeguarding their health. Individuals have a responsibility to educate themselves and take appropriate preventive measures to protect their health, safety, and well-being. The Government, health care providers,

and consumer organizations share in the responsibility to educate the public about health care. Differentials in contributions for health care coverage to encourage healthy behavior can be appropriate as long as they do not deny access to health care.

Long-term care should be provided to all individuals through a comprehensive public program based predominately on social insurance principles (e.g., Social Security). Ultimately, the health care and long-term care financing and delivery systems should be integrated.

AARP LONG-TERM CARE PRINCIPLES

Long-term care services should be available to all people who need them, regardless of age or income. Eligibility should be based on cognitive and functional limitations, such as dependencies in eating, bathing, and dressing.

A national long-term care program should provide a comprehensive range of institutional and non-institutional health and social services. Long-term care should be provided in the least restrictive setting possible.

The new public program should assist, not replace, current informal caregivers. Families and friends need access to supportive services so that they are not unreasonably burdened and can continue to provide care.

The principles of social insurance and shared risk must be extended to long-term care. By spreading the cost across the entire population, protection can be provided in a more affordable, equitable manner for any one person.

The new public program must be self-financed so that it does not increase the Federal budget deficit.

The new long-term care program should be financed primarily through taxes that could be earmarked to a trust fund for this purpose, making the Medicare payroll tax a possible revenue source. Additional sources could include increased estate and gift taxes, income taxes and modest premiums.

Cost containment mechanisms must be built into the system. Modes deductibles and copayments should be included in the system, along with strong care coordination.

Protection for low-income persons must be provided against the cost of premiums, deductibles and copayments.

Provider reimbursement must be adequate and structured to ensure high quality care and access for all.

Implementation of the public program must be phased in to ensure orderly development of the new system and all of its services. The first priority should be expansion of home and community services.

The new public program must provide a solid foundation for protection, upon which the private sector can build, with supplemental coverage of copayments and deductibles, as well as additional services not covered under the public program.

The CHAIRMAN. I thank all the members of the panel. You have different approaches to this issue.

Listening to you, Ms. Archuleta, as you mentioned the polls that have been taken of the American people, supporting health care reform and a more comprehensive system, the question then comes down to what percent of the people are prepared to pay for it. Then we obviously find some falling off.

And then, I mentioned to Congressman Gephardt the role of the Federal Government in terms of the reforms, given the very broad amount of skepticism and cynicism about government involvement in public programs. We always hear that, and yet when there is a crisis the first thing people say, whether it is the savings and loans, the Bank of New England, price supports in agriculture, Medicare or Social Security, air traffic controllers or toxic waste dumps, is why isn't the Federal Government doing something about it. So there is obviously ambivalence, and at least I believe that it is not a question of anti-government or big government or smaller government—but better government.

I'd like to just hear from the members of the panel what you think is the appropriate role for government in this particular challenge.

Ms. THORNTON. I think government has several roles that they should play. I think they do provide a safety net for individuals who cannot afford access to appropriate health care services.

I think government should also provide enabling legislation which will provide the framework under which new solutions can be worked out and trailed. I think there are obviously some areas within our health care delivery system and our health care system in general that need rectifying. One of these is coverage for small employers. And I think there are solutions with pooling arrangements that can be worked out which would help to ameliorate the situation that we have today.

The CHAIRMAN. Ms. Shearer.

Ms. SHEARER. I think that ultimately the Federal Government should be responsible for assuring that all Americans have access to health care. There are several different ways that this can be done, but at this time just so many millions of people are falling between the cracks that ultimately the responsibility has to be for a Federal Government safety net.

Turning to the issue of long-term care, we have found consistently that the private market is incapable of solving these problems, and we conclude that there is definitely a need for a public sector role to assure that all Americans have access to long-term care.

So we conclude in both areas that there is a major responsibility for the Federal Government.

The CHAIRMAN. Dr. Nelson.

Dr. NELSON. I agree with the other panelists that the role of government is to assure that those who are unable to provide for themselves are covered; that everyone below the poverty level is covered by a decent benefit structure in the Medicaid program; second, to assure that people who are employed are covered where they work, which has traditionally been the way that most Americans have been covered; third, to assure that States provide risk pools so that those who are self-employed can purchase insurance at group rates. And finally, obviously, there is a role for government in protecting the public from exploitation, so there is a certain regulatory responsibility that government should properly fill.

Ms. ARCHULETA. In AARP's list of principles, you will probably note that we have indicated that the financial part of health care reform should be borne by government, by employers and by individuals. But we share some of the same points of view that have been expressed here.

The CHAIRMAN. Dr. Nelson, back to the cost containment proposals that you have, and then I would be interested in recommendations that others might have.

I think all of us understand that it is going to be very difficult to expand the coverage in terms of the unemployed and part-time, unless we are going to demonstrate a seriousness about cost containment. I happen to be serious about it. I led the fight for President Carter's cost containment program years ago and was defeated on the floor of the Senate. So I think we understand that there has to be this feature, and there should be.

You make a series of recommendations in your testimony, and we'll have more time after these hearings to examine it, but perhaps you could make some comments as to ways in which we can be more effective in terms of cost containment and what you would like to see included in any kind of program.

Dr. NELSON. Sure, and my comments have to apply across-the-board, because it is easy for government to simply say, "This is all we are going to pay," and then have the private sector pick up what they don't. But let me personalize it. When I go to my office I don't go with the intention that, well, today I will drive up volume, or I think today I'll generate some health costs. I try and approach each patient's problems and try and find a reasonable and scientifically valid way of dealing with that.

And most of the things that I do every day were not even available 10 years ago. My father's heart attack 2 years ago that took him would be treated differently today. Chris a few years ago, instead of having an MRI for his seizure disorder, would have had an air encephalogram, which would have been a terrible experience for him.

As a small businessman, which many physicians are, my premiums for the small group we are in went up 50 percent this year, a truly staggering part of our overhead.

Let me tell you the kinds of things that I think we should enact. Appropriate cost-sharing for those who are able to afford to pay a portion. That is one of the keys to volume control. The marketing that is going on, the information-driven nature of our society, is driving up the volume of services.

I have patients come in with three cholesterol measurements that they have had in 3 weeks, to see if their oat bran is working. Appropriate cost-sharing makes people more prudent purchasers.

Second, health promotion. It does not make any sense to spend $3 billion advertising tobacco products in this country, and that is something that Congress should deal with.

Third, effectiveness research. We need to do more research to find out what has value, the way to solve problems in the most cost-effective fashion. And part of that is practice parameters, which is general acceptance of strategies for physicians to follow that are based on consensus, to do away with some of the uncertainty in the variation in the way we solve our problems.

Fifth, continue the reform of physician payment. We have taken some very important steps in dealing with the inequities that everybody knows exist, and we need to pursue that path.

Sixth, permit fee review at the local level by groups of physicians. I have businessmen ask, "Why don't you deal with your bad apples?" I tell them that local county society committees that embark on review of patient complaints about fees run real risk from antitrust actions. That is something that can be dealt with and should be.

Seventh, cut defensive medicine costs. I don't need to say anything more about that because I know you have heard about it.

Eighth, cut down the administrative burden. I saw a patient in a nursing home just before I came here and wrote orders at the bedside, and I can guarantee that there will be mail on my desk for

me to again sign those orders, simply because long-term care is so administrative burdensome, the paperwork volume.

If I am trying to deal with a diabetic as an outpatient instead of putting him in the hospital, measuring blood sugars more often than the computer screen permits, then I get a letter saying that those services were not necessary. The hassle is not free; the hassle costs us something.

Finally, I think we have to continue to study the process by which society sets its priorities. It is easy to say that we should as a Nation invest more in prenatal care for pregnant women than for hair transplants for 80 year-old men. It is a bit tougher when we decide whether we should pay for a second coronary artery bypass process for an 85 year-old man or a third liver transplant for a child.

We then have to continue the study of the way by which those priorities are set, with an ultimate goal not perhaps of limiting cost, but at least rationalizing the way we spend for health.

Thank you.

The CHAIRMAN. Do others wish to add to that?

Ms. SHEARER. If I could just add to that, Senator Kennedy, that the issue of cost control was probably the most important, or maybe the second most important reason that Consumers Union concluded that a single payer system has the best bet of significantly reducing and controlling costs.

I thought that Congressman Gephardt had an excellent suggestion this morning in taking a look at the DRG experience which has been so effective in controlling hospital care costs for Medicare, and we should think about applying that to the under-65 population and to the physician services. I realize that is not an easy thing to do, but it is certainly worth pursuing.

Ms. THORNTON. Mr. Chairman, we would also recommend that the managed care health care systems are a way of controlling costs in that they look at the provision of health care on a total basis; they ban providers, consumers and intermediaries together in an arrangement which is committed to controlling cost while it improves quality and applies other management techniques to the provision of health care benefits.

The CHAIRMAN. Very good. I would ask the committee's indulgence since I am over my time. Dr. Nelson, you mentioned the malpractice insurance. There is about $300 million a year that has gone for community health centers. About $75 million of that is paid in insurance for doctors. When it was operated by the Public Health Service, liability insurance was covered under the Federal Tort Claims Act, so there wasn't any. So we have lost $75 million worth of services.

We have community health centers that don't have any insurance, who just say, "We're going to keep going and take our chances." The interesting thing is they don't have cases against those doctors because the doctors are really out in those communities and really have the confidence of those communities. I am sure there are incidences where there may be some difficulties or some negligence—hopefully not. But when you mention that, it really rings a bell.

Senator Hatch and I tried to do something about it, to give CHC's a status like they had in the old days, allegedly permit them to be under the Federal Tort Claims Act, and the trial lawyers came out of the woodwork.

But in any event, I know you referenced that and we did not get into it, but as we move through the development of legislation, we'll want to hear a good deal more from both you and the other members of the panel as to how we can deal with this.

Senator Durenberger.

Senator DURENBERGER. Thank you, Mr. Chairman.

I apologize am supposed to be in a meeting in the Republican Leader's office at 11:00, so I will be brief.

First, I remember the Carter cost containment vote very well. I remember the result was a one vote margin on our side, and I always took credit for it even though I was brand new. But I also remember that on the other side, the person who really killed it was the first witness here this morning—and I won't make any comment on that other than that is sort of the reality of the way things work around here.

I think all of us have been searching for answers to these questions for so long, and while we may be perceived from time to time as being on different sides of an issue, it is only because some of these issues continue to change.

I thought Alan just touched the tip of the iceberg on the differences in just 2 years in medical technology. That is a reality out there that none of us know how to grasp. This committee has jurisdiction over a major part of that issue, but where do you head in on it? How do you get your hands around it?

I spent a fascinating 2 years on this committee in the 101st Congress just trying to learn a little bit about technology and the medical device bill and the orphan drug bill—more money was spent lobbying the orphan drug bill than what we spent on maternal and child health care in this country; it drives you crazy.

I have one question I'd like to ask because it gets to the issue of one of the main areas in containing costs, which is to contain access in an appropriate fashion. I suppose I want to ask this question of Martha and Gail, and I'm going to use Martha's testimony to ask it of Gail.

"Ameritech believes that employment-based approaches are the preferred vehicle to expand coverage. While employers can help employees, the ultimate responsibility must rest with the individual. We know from other employers that even in the presence of a plan provided and primarily funded by the employer, some employees choose to forego coverage. Employers should not be penalized for choices made independently by employees."

I could go on and on and quote other things, but the part that I wanted to point to was that Ameritech believes that there is value to the system, to the people involved, I take it, and to this whole process of improving the access to quality care and having a role for the employer in this system.

Consumers Union believes we ought to look to Canada. If I understand anything about using Canada as a model, it means we cut out the Martha Thorntons and the Ameritechs and the relationship between the employer and the employee and the income secu-

rity system, and we substitute the State government or some government to manage access. I must just say, having said what I just said about where we have been over the last 13 years, I have a really tough time getting there.

I can't endorse what is going on anywhere other than at the Ameritechs and some of those places in the employer sector. I certainly don't endorse what is going on in health insurance these days. But before I go to Canada and ask people like us to try to make these decisions, I need you, Gail, to tell me why we should pass up Martha Thornton and Ameritech for the State of Massachusetts, the State of Minnesota, or even—I'd probably trust Utah before I'd trust a lot of other places. But why?

Ms. SHEARER. Well, there is a lot to be said for the system that we have today, and I don't mean to imply that this is a black and white issue.

The biggest flaw that Consumers Union found with the employer-based system and building on it is the question of cost control, which has already been discussed this morning. We have not been able to figure out the best way to really build cost control into an employer-based system. It is a challenging problem. It could be done.

If this Congress is going to be committed to ensuring universal access through an employment-based system, we will work with you and try to make it work. It wouldn't be our first choice, but it certainly has great potential.

Senator DURENBERGER. Thank you. Any comment, Martha, on the Canadian system?

Ms. THORNTON. I did want to make a comment, Senator. With me today is Alan Paris, who is a manager of benefits for Ameritech. Prior to working for Ameritech, Alan was a hospital administrator in Montreal, Quebec and worked under the Canadian health care system. And while the Canadian system does provide access to the population, it is not without its own set of problems. In essence it is a fee for service system with expenditure cap placed over it. Because of that, even though there is access there are also severe shortages within that system, both in certain kinds of facilities and also in the provision of services to patients on a basis selected by the physician providers.

Senator DURENBERGER. Good. Thank you all very much.

The CHAIRMAN. Senator Pell.

Senator PELL. Thank you, Mr. Chairman.

Following up on this question of the Canadian insurance and the British, I think we all agree that in Great Britain, as I understand it, there are certain procedures which they just don't do. For example, you don't get kidney dialysis if you are over 65. And there are other procedures of the same sort that seem too draconian in those that it would exclude.

At the same time, as you know, in Great Britain they have private hospitals where they charge a great deal, and you can still get that sophisticated medicine if you can afford it. That is a fact, I think.

I would ask unanimous consent to insert in the record at this point a table comparing the three health systems, U.S., Canada and Britain, and it is interesting from a cost standpoint, percentage

of GNP as of 1989, about 6 percent of GNP was spent on health care in Great Britain, 11.5 percent was spent by the United States, and about 8.5 percent by Canada—right down the middle between the two of us.

I was wondering, pressing Dr. Nelson for a moment, where you feel the Canadian system is short. It obviously does not cover certain procedures. And your own system, which seems pretty good to me, too, does not cover certain procedures.

Dr. NELSON. Yes. Our minimum benefit package is the minimum decent benefit package. But the Canadians count their numbers a bit different than we do, Senator Pell. For one thing, we have different ways of depreciating the facilities that they don't count. There are certain aspects that the Canadians don't count as health costs that we do—home health care might be an example. The trend line is relatively parallel—and they are concerned about health costs just as we are.

The British—it is curious that at a time some are talking about nationalizing our system, the British are talking about privatizing theirs, and both for the same reason—to save money.

None of that says, though, that we ought not to correct the deficiencies in our system. I think the critical question is what is doable. I think it would be a tragedy for us to have a national debate for two decades over whether to adopt the Canadian model, while we have 32-37 million people who could be insured and are not being.

In this country we pay somewhere around $150 billion in out-of-pocket costs. If we adopted the Canadian model, the tax burden would go up somewhere into the high 40 percent. The Canadians have a higher tax than we do; they have a higher per capita national debt than we have, and part of that is because they have free-at-the-point-of-access medical care.

But if we were to adopt the Canadian model, our costs would skyrocket because efficiency would go down because governments don't seem to be able to do things very efficiently; because the demand for services would go up because it is free at the point of access, and nobody in this country will tackle the problem of rationing that the Canadians have tackled—and I don't think that we should.

Our Nation is rich enough that we don't need to ration medical care. We need to rationalize medical care.

Senator PELL. I congratulate the chairman of this committee for calling these hearings and for the leadership he has taken. I think he started taking a leading role in 1962 and to make some progress here. And yet we all know the problems; we admire those who are trying to overcome those problems, but we still face many of the same obstacles that we did almost 30 years ago.

How do you see us breaking through in this?

Dr. NELSON. Adopting a program like Health Access America, which is doable; expand Medicaid and make it decent, and increase the number of people insured where they work, and set up State risk pools.

Senator PELL. What would be the basic differences between your plan and the Kennedy employer-based health plan?

Dr. NELSON. Many similarities. The differences are in terms of details. Conceptually they are very similar insofar as the required employer coverage portion is concerned.

Senator PELL. I have no further questions. I'd like to know if the chairman shares the same view.

The CHAIRMAN. Yes, I do, particularly as to how we deal with the smaller businesses; I think a lot of those issues were addressed in very significant detail in the Pepper Commission, in centers, and in phasing in, and in pooling of various insurance markets. I think if you look at where we started out, where we have mandated benefits, they have a sort of pay-or-play for employers, which is entirely acceptable as an alternative way of dealing with similar issues. Where the Pepper Commission and the AMA differ, we could probably work out in a couple of hours.

The real problem with this issue is not that we need to know more about it; is that we need the will to address it. We have had study after study on it. But I think there are areas of broad common agreement. There may be some areas of difference, but there are broad areas of agreement.

Senator PELL. Thank you very much. I have no further questions.

The CHAIRMAN. Senator Simon.

Senator SIMON. Thank you.

First of all, I really think there is some coming together, and there is no better illustration than if 10 years ago you were to say the AMA and Senator Kennedy are in agreement on a health care bill, it would have been revolutionary.

Dr. Nelson, you said we need collaborative efforts to devise where we should go. How do we achieve these collaborative efforts?

Dr. NELSON. I think it gets back to what the chairman said about the requirement for will at the beginning; and then after that it takes a major commitment to get the players within society to agree that something needs to be done and that this is a reasonable way to proceed. And the AMA put me on the stump in a lot of places last year with business groups and others in trying to urge that we confront these problems. So by collaboration I mean getting the people who make the decisions to reach some sort of compromise, and first of all to understand that we have to have some changes.

Senator SIMON. But it seems to me we are at a point when people like Lee Iacocca are saying we ought to adopt the Canadian plan. Whether you are for it or not, an important representative of business is calling for it. I met with the officers of one of the Fortune 500 companies who say we have to change something. And when a Peoria businessman says to me, as he did recently, that "We budgeted $800,000 for our health insurance, and our bill came in at $1.4 million," it shows he is ready to do something. I think we are at the point where that collaborative effort can be productive. And I agree with you we should not look at this point for overall long-term changes. I'm not against looking for those changes also, but I think we ought to be looking first at what can we do about long-term care, what can we do about some of these very specific needs. I think we really are ready for these.

For example, if the four of you, representing very diverse interests, and those of us here were to get together, I think you would find that we could agree on some fairly significant steps forward.

Ms. Thornton, first of all, it is good to have an Illinois representative on the panel. You say we must find ways to make coverage affordable for smaller employers and individual purchasers of health care plans. Do you have any specifics on how that should be done?

Ms. THORNTON. I think a couple of things need to be done. I think we do need to have risk-pooling arrangements. I think we need to look very carefully at some of the State mandates and evaluate whether or not they really add to the effectiveness of medical care or simply to the costs. I think those are some of the major issues that we need to address.

I think we also have to be sure that we have enabling legislation which allows managed care systems to develop within the small group market so that those employers also have access to the kinds of systems that major employers do.

Senator SIMON. You also mentioned somewhere in your statement—and I think it is an important thing for us in Congress to keep in mind—that "government should not use its legislative powers to systematically underpay providers."

Every year now, we go through this, where we get a recommendation to cut back on Medicare. It sounds so simple when we are putting a budget together—and I am on the Budget Committee. They called for cutting back $5 billion, and we finally compromised on $2.3 billion. When hospitals and physicians and others are not paid for their real costs, they shift them over to those who can pay.

Ms. THORNTON. Exactly. We see that as a hidden tax on those people who are ill and who have to access the medical system because they are the ones who end up picking up those additional costs.

Senator SIMON. And so Ameritech in a very real sense picks up the tab for our failure to provide adequately for Medicare.

Ms. Shearer, in your statement on the financing part, the financing should be progressive; I gather that you favor this and making it part of the income tax in some way.

Ms. SHEARER. We have explored several options especially with regard to long-term care. We have thought about payroll taxes, probably modified by making a less severe impact on low-income people; gift and estate taxes are a potential source of revenue for a long-term care program. We have done a detailed study of the possible financing of several different long-term care options including one that Senator Kennedy introduced in the last Congress, which did a very good job in meeting the criteria that we lay out for a long-term care program.

There are some options, and we feel it is doable.

Senator SIMON. And Ms. Archuleta, clearly, as you look at the demographics, the long-term care issue is going to explode on us. Do you have any recommendations for how we will pay for a long-term care program?

Ms. ARCHULETA. Well, AARP believes that it probably should be based on a social insurance kind of system. We have had good response from the public on Social Security and Medicare, and there

would still be a role for private insurance over and above the kind of basic long-term care plan.

Senator SIMON. I thank all of you. I think it has been a good panel.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Adams.

Senator ADAMS. Thank you, Mr. Chairman.

Ms. Thornton, I want to direct most of my questions to you because the chairman and I—if you can believe this—as early as 1962 and 1963 visited the group health facilities in Seattle, which were among the first HMOs, and managed care types of health plans in the country. Therefore, I am very interested in how you developed your managed care plan as an employer. I believe this is one of the ways that health care can be provided in an effective and less costly manner. Often they are much more flexible. How did you develop your managed care plan? What bases did you use?

Ms. THORNTON. Most of our employees are represented by two unions. We have worked in conjunction with those two unions through the negotiation process in developing a comprehensive health care plan in the 1986 bargaining. As a part of that plan we introduced manage care provisions, and we also developed preferred provider arrangements. We did the preferred provider arrangements in conjunction with the local Blues plans, who worked with us in developing criteria to select hospitals and physician providers to become members of that organization.

The new plan that we will be introducing this year and next year, again, that plan is being developed in conjunction with the local Blues organizations and in partnership with them, and we are entering into a risk-sharing arrangement with them to oversee the provision of medical benefits under this managed plan.

Senator ADAMS. How are you evaluating the results of your plan so far? You mentioned risk-sharing. I think the big problem—and I happened to be in the Carter administration in the Cabinet at the time when we were doing cost containment, and I remember Secretary Califano coming up, and our problem always seemed to be that we have the division between providers, in other words, those who pay and who use the service and those who provide the service. And once you break that nexus, the market obviously doesn't begin to work. The solution it seems to me has been where you combine and get pre-agreements of physicians, and that is what I am searching for with you: How did you create your plan? Senator Kennedy and Senator Mikulski and myself and several others are trying to find a way to provide access to the 37 million Americans with no health insurance. We have been trying to get a series of insurance companies to pool resources, to establish a basic plan. But we couldn't get a rate from any of them. We even tried to tie it into the minimum wage, where a certain percentage of the cost would come out of that. But we did not have the nexus that I referred to. Could you describe how you got the agreements among the three parties so that you stabilized the system?

Ms. THORNTON. The point of service plan is a plan which is under development today. The way that will work is that Blue Cross actually holds the contracts with the providers. Those contracts are

based in some cases on a capitation arrangement; in other cases it is a per diem arrangement if it is a facility-based provider.

Our arrangement with the Blues is based on current cost plus the trend rate, and the Blues guaranteeing to manage costs within a certain level.

Senator ADAMS. But you have a fixed cost basis for a series of services, do you not? I should not put that as a rhetorical question. I am asking you that question.

Ms. THORNTON. It is not fixed in our case. In our case, the system will have an overall cap, and within a percentage range above that cap there will be some sharing if the Blues exceed the amount of expense that has been targeted for the year. If they are able to bring costs in at a lower level, then there will be some sharing of the savings.

Senator ADAMS. Some sharing of the cost savings, which I think is an incentive and is necessary.

How is this working in your region?

Ms. THORNTON. It is under development right now, Senator Adams, so we cannot speculate on that. We do know that for some other major employers, though, Southwestern Bell, for example, being one of them, who has established a point of service plan, that they have been able to control costs over the last 2 years, averaging an increase of about 7 percent on a year over year basis. So they have been able to do very well under this kind of a plan.

Senator ADAMS. But you use an overall package with a series of doctors who become your preferred provider system; a bulk set of money is allocated, and then your incentive package is worked against the bulk.

Ms. THORNTON. Yes, essentially that is it.

Senator ADAMS. OK. Dr. Nelson, I very much appreciate your being here. One thing that I am concerned about—and we passed legislation last year on pap smears and that type of examination to examine for cervical cancer, and we intend to proceed with legislation this year, and the chairman has been very helpful in these matters, on mammograms and getting really good screening because our incidence of breast cancer, particularly among older women, is rising. I think it was 40 percent these last couple of years, so it is just on an upward trend. I notice that is not covered in your basics. I agree with most of the rest of your basics, but I am also a great advocate of if we can do some preventive care here, we save an enormous amount in terms of later surgical or crisis care.

Have you considered placing some of those kinds of tests within your basic coverage, because they are not terribly expensive, and there is a definite schedule—I mean, you can establish a schedule of once a year or something like that, so that you don't have a great volume. I just wondered why they were omitted.

Dr. NELSON. Well, first of all let me say that I agree with you 100 percent on the desirability and cost-effectiveness of mammogram screening. And we were strong proponents of inclusion of mammogram as a covered benefit in the Medicare program. To some degree, then, our lean minimum benefit package is inconsistent with our policy, and the way it was arrived at was starting at

$1,700 per person, and then our actuaries went as far as that would go.

I think that some of the copayment levels are too high, also. So it is not perfect, and I'd like to see mammogram screening included in that, and so I agree with you. This was the first iteration of this minimum benefit package, and as I said, we started out with a set amount of money and then tried to prioritize what would be purchased—understanding that this would be the minimum and that ideally people would be purchasing packages that would include more coverage than what this provides. I think you will probably find us including that in the future.

Senator ADAMS. Thank you, Doctor.

Thank you very much, Mr. Chairman.

The CHAIRMAN. Thank you.

Dr. Nelson, just a couple little comments. In terms of the administrative costs, if you take the cost of Social Security versus the administrative cost of private insurance you will find that in the private sector it is considerably above what Social Security costs just in terms of management. And the contrast between administrative costs in Canada and the United States in terms of the private sector is rather dramatic. I don't know whether you have had a chance to look at that. I am not making the argument that the government always does things very well, but in the health care areas, the private sector, particularly on administrative costs of health care—the rest is something that we have to recognize as well.

The other thing is in terms of the overutilization. You gave us pretty good examples of overutilization. But we had that situation in Saskatchewan where they put in just minimum payments for utilization of outpatient services—a couple of dollars—and then they evaluated over a period of years to get people to stop coming down to doctors' office, and it had very little impact.

I don't question that there are a lot of people who think they've got a lot of problems, who take up much too much of the doctors' time—you are certainly an expert on it. But for the most part, most people are working, and they are working hard, and they've got families, and to go down and take up a doctor's time—usually, it's difficult to get them down to those offices to do the kinds of things that various members have commented on in terms of preventive care so things don't deteriorate.

I am sensitive to the things that you have mentioned. There are a lot of people with much too much time on their hands, with nothing to do, who are taking up the time of the doctors, and we do have to deal with that, but we also have the highest copays in the world, and there is a certain group of professionals who think that in and of itself keeps people away. Certainly, the costs of emergency rooms when people don't have any health care coverage—$7,500, and you have a child who is sick, and they have to wonder whether it really is worth $100, or whether they'll wait another day before they really know the child is sick, and by that time the child is very, sick.

Dr. NELSON. Well, let me respond, because I don't want to be misunderstood on this.

The CHAIRMAN. OK.

Dr. NELSON. My patients don't come to see me unless they really think that they ought to be there. Nobody goes to see a doctor, particularly if they have to wait very long, unless they either have something wrong, or they are very concerned that they might.

What I was saying is that the information-driven nature of our society has arrayed such an incredible menu of health services that are being marketed so people don't know whether to have bone density screening, for instance, or not. And if they are able to participate some in paying for it, they are more liable to ask the doctor the searching question "Why do I need to have this done?" And agreement on services that are provided should come from a partnership between doctor and patient. But the patient will be more likely to ask those questions if it isn't "all free".

The CHAIRMAN. I think we're probably not talking at odds. I think it is the information and having informed both patients and doctors.

As you can gather, we are very serious. This is a top priority of mine and of our committee. We will include all your written statements in the record; they have been very helpful. And we will be coming back to you for additional suggestions. We hope that today we might have jarred your thinking as well on some additional things that can be done. We are very grateful to all of you.

[Additional statements submitted for the record follow:]

PREPARED STATEMENT OF SENATOR MIKULSKI

American families, and especially the women in these families, are increasingly shouldering the burden of caring for the growing numbers of elderly in our country. Sharon Burton, from my home State of Maryland, is a good example of this. Ms. Burton not only cares for her immediate family of a husband and three children, but also cares for a grandmother with Alzheimers disease and a mentally retarded aunt in her home. The grandmother herself had been providing care to the aunt until her own illness and a broken hip prohibited her grandmother from providing further care.

I think that it is wonderful that there are so many outstanding, dedicated, tireless people like Sharon Burton, but it is time that this country started supporting and caring for its caregivers. We cannot depend upon the free labor of people who have many other responsibilities—both within the family and in jobs and activities outside of the home—for the health care needs of our elderly and disabled. Women make up over half of the American labor force. Yet the majority of health and personal care in the home is also provided by women.

It is time that our public policies catch up with the stated values of this country. We talk about the importance of strengthening the family, caring for the sick and the elderly, and giving our children a good start in life, yet the Administration refuses to support bills such as the Family and Medical Leave Act, which would provide some security and support to workers who must care for family members who are sick or require care. It makes good public policy as well as economic sense to care for our caregivers.

We need to address the lack of access to adequate health care in this country in a serious manner. Long-term care coverage issues

will only become more pressing as our population continues to age. We need to ensure adequate coverage for health care delivered in the home, and coverage for services along the entire continuum of care. And we need to ensure that the care that is given is quality care, by supporting bills such as Senator Adams' and my mammography quality assurance bill.

Once again, I would like to commend Ms. Burton and the other citizen witnesses for being here today. They deserve our best efforts to get them the help they need.

A Comparison of Three Health Systems: United States, Canada, and Britain [1]

	U.S.	Canada	Britain
Universal coverage	No	yes	yes
Financing	public, private	provincial taxes	federal and national government taxes
Physician Status	mostly private	mostly private	government employees
Hospital Ownership	mostly private	mostly private	government
Payment to Physicians	private insurers, government, individuals	government fee-for-service	government salaries
Controls on Physician Costs	no systematic controls	fees adjusted for budgeted expenditures	salaries established within budget targets
Payment to Hospitals	private insurers, government, individuals	government	government
Controls on Hospital Costs	no systematic controls except for Medicare DRG system	budget for each hospital established by government	budget for each hospital established by government
Limitation on Availability of Care.	Financial resources of individual or insurer	No Limit	No formal limit but severely constrained resources result in waiting lists and denial of access to some costly procedures for older people or those thought to be bad risks
Cost of System	10.7	8.4	5.9
(percent of GDP/1984)	11.1 (1988)		

[1] Information provided by Senate Labor and Human Resources Committee (March 1989)

Prepared Statement of Senator Bingaman

Mr. Chairman, let me begin by commending you for holding this hearing today. Many of us look to you for leadership in our efforts to help improve the Nation's health status, whether in the area of AIDS prevention and education, children's health care, medical research, or any number of other health care fields. I am confident that you will be a capable, committed leader in the 102nd Congress, and I look forward to working closely with you.

The issues that we will discuss this morning—the current state of our health care system and the right of all Americans to adequate health care—are among the most critical issues facing our Nation today. With the excellent help of today's witnesses, I am confident that we will be able to develop and enact some realistic solutions to these problems.

Working together at all levels, I believe we can make a difference. for the sake of our children, their future, and the future of our Nation as a whole, we need to rise together to meet the challenges facing our health care system. The costs of failing to act, in terms of lost productivity, lost revenue, and lost lives, are simply too high.

As a nation, we spend more on medical care than any other industrialized country. Estimates are tat in 1990, our total health care expenditures topped $600 billion, which is twice the average of our international competitors. But despite our astronomical spending, our Nation's health status—and the accessibility of health care in general—are tragically lacking:

Every year, more babies die because of sickness in the United States than in almost any other industrialized country;

Every year, hundreds of elderly individuals and their families face losing nearly everything they own because of astronomical hospital and prescription drug bills;

Every year, fewer and fewer people can afford health insurance; and

Every year, more and more Americans become the victims of AIDS and other deadly diseases.

Clearly, something is wrong. somehow, we have developed and are perpetuating a very inefficient health care system. We are spending more and we are receiving less. Our children's future—and our Nation's future as an economically competitive force in the global marketplace of the 21st century—are at severe risk if we do not start making changes today.

Where do we start? As with any successful strategy for dealing with a problem, a recognition that the problem exists must first be made, and then the problem must be defined in realistic terms. This hearing signals the recognition that a problem exists.

In my view, the challenge of health care can be defined in three ares: First, cost; second, access; and third, quality.

These are three formidable issues, and perhaps that is part of the reason we are in the mess we're in. We are looking at the challenge of health care in terms that are too broad. We're trying to come up with solutions for our entire health care dilemma, from lack of prenatal care for low income, minority women, to the escalating costs of nursing home care for the elderly.

Perhaps those goals are too ambitious, at least for now. I believe we need to identify some realistic priority areas and work toward developing step-by-step and level-by-level plans for reaching goals in those more limited, but critically important, areas.

If we set realistic priorities and goals, I believe our ultimate goal of assuring access to adequate health care for all will be easier to achieve.

What should our first priority areas be? I believe that economic realities and the need to help secure an economically competitive position for the United States in the next century demand that we first focus on preventive and primary care for our children.

I am convinced that we can fulfill our responsibilities to the next generation and maintain our competitive position in the global marketplace only if we help our children to become health, productive adults. We must assure them of their rights to adequate health care and education early on.

Unfortunately, we are failing miserably at this task. Last year, the Children's Defense Fund published a report measuring trends in our children's well-being over the past decade. I was deeply disappointed to read that my home State of New Mexico—and 47 other States—were given failing grades in that report. If we truly

care about our children and their future, all of us should be ashamed of the findings of the CDF report, and we should pledge to improve the situation before the end of this decade.

New Mexico failed in 18 of the 20 categories. We ranked last in the ability to provide prenatal care, 48th in the teen birth rate, and 45th for children living in poverty. How do we expect to secure a bright future, a competitive future, for our children with statistics like that? The answer is that we simply cannot.

That is why, in the area of health care, I believe we must make preventive, primary care for all children our first priority. I hope that other members of the Labor Committee and the full Senate agree with me. I hope that we can work together to develop realistic strategies for securing adequate prenatal care for all pregnant women and adequate preventive, primary care—including health education—for all our children.

It is an enormous task, but one that I believe we can achieve if we work together at the local, State, Federal, and most important, the family level. We can do it, and this hearing—the Labor Committee's first hearing on health issues in the 102nd Congress—is an excellent starting point.

Thank you, Mr. Chairman, once again for convening today's hearing. I look forward to a morning of insightful testimony.

Prepared Statement of R. B. Howard, Senior Vice President, BellSouth

On behalf of BellSouth Corporation, this statement is submitted for the printed record of the January 10, 1991 hearing before the Senate Labor and Human Resources Committee addressing the Nation's health care crisis.

BellSouth is one of the seven regional telecommunication companies formed with the divestiture of the Bell System. BellSouth has approximately 102,000 active employees predominately located In the nine southeastern States and approximately 34,000 retirees located throughout the United States.

The inaccessibility of this nation's health care system, while a serious concern, is symptomatic of a more fundamental problem. Rather than a band-aid approach, BellSouth advocates legislation that would address the broader problem of the cost of health care.

According to the recently released Health and Human Services Department information, national health care expenditures were $604 billion in 1989, up 11 percent from 1988. This sum represents 11.6 percent of the nation's GNP, up from 11.2 percent in 1988. These figures and the trend that they depict underscore the real problem plaguing this nation's health care system—the cost of medical services. Simply mandating employer insurance coverage for basic medical services will not correct this problem, it will only exacerbate it.

As it is now configured, the health care system in this country is unfettered by the economic pressures that influence other businesses. The medical care consumer is not equipped to do comparison shopping. Even if that were not the case, once a patient enters the system, most of the medical demand is set by the physician who is also a major supplier. The result has been, and without system correction will continue to be, runaway medical costs. Much of this cost is absorbed by employers, especially as public medical programs, such as Medicare, reduce their payment levels in order to meet budget targets.

BellSouth believes that the following fundamental changes in health care policy are necessary:

(1) Comprehensive basic system changes are necessary since piecemeal changes will not work. Piecemeal changes have been tried and the cost of medical care continues to rise while access to the health care system becomes more limited.

(2) The health care delivery network is too large and its facilities are poorly located. As a consequence, preferred provider agreements or other so called managed care systems that buy services at reduced cost simply result in cost shifting rather than address the system's inefficiency.

(3) Any public programs that expand coverage or provide coverage of last resort could be appropriately funded with dedicated and broad based taxes. The amount of public support could be based upon the individual's ability to pay.

(4) The level of demand that has been and will be placed on the health care system cannot be met. System controls and/or prioritization must be considered that will assure the maximum benefit from the resources and limit health care expenditures to a level that the economy can afford to fund.

The foregoing, or any other social health policy initiatives, should not be undertaken until their long-term impacts have been thoroughly evaluated. BellSouth submits that the evaluative process has not been undertaken in the case of mandated employer funded health insurance. Full consideration must be given to the impact that such mandated action will have on employment and the competitiveness of American industry. BellSouth endorses the changes made in the Omnibus Budget Reconciliation Act of 1990 which require any new social program be contingent upon procuring proper funding. BellSouth is of the view that funding consideration should be for the long term and not just one fiscal year. Otherwise, there will be a constant problem in developing proper sources of funding for a program of this magnitude.

An examination of state legislative initiatives that have mandated certain types of medical coverage or provided coverage for a specified group of providers shows that these actions have increased medical costs. This associated cost escalation has resulted in an overall reduction of coverage as many small employers have been priced out of the marketplace. Larger employers have opted for self-insurance to avoid these costly, unwise state mandates.

Cost then is the real issue confronting the nation's health care system. Mandated employer coverage addresses access to the system but does not confront the cost problem. A better approach would be to offer reasonably priced "basic coverage" that an employer and an employee could jointly or separately purchase, coupled with fundamental reform of the supplier network. In that regard, consideration should be given to:

(1) Imposition of effective coordinated area planning. Too many facilities and too many specialty providers are creating an inefficient medical delivery system.

(2) Fundamental malpractice reform associated with scientifically evaluated standard medical protocols and procedures are needed. with these standards, controls can be placed on the malpractice awards when the provider adheres to the standard practice guidelines.

(3) An all-payor system that fixes payment schedules equally for participants within a geographic area. The rates should be fair to the provider as well as the purchaser and, everyone including the government, would pay their appropriate share. In that regard, an approach similar to the relative value system or the Diagnostic Related Group that sets the Medicare payment levels should be considered.

(4) A system that sets priorities and limits expenditures similar to the Oregon Medicaid proposal.

BellSouth also recommends a study of the health care systems used by other countries to determine how they provide medical services to a greater percentage of their populations at costs that are much lower than those in this country. From this study Congress could formulate a plan that incorporates the best aspects of our system and those of the countries that were studied. This could result in an expansion of the employer based system.

As far as long term care for the chronically ill is concerned, we do not believe that a new social program of this magnitude should be implemented, if at all, until the current medical care cost crisis is addressed. It is true that the current Medicaid system does not adequately address the needs of the chronically ill, but the addition of another major public program with such high costs should not be undertaken with the current budget deficits. Since long term chronic care is in most respects associated with the aging process, the current retirement system, including social security could address part of the problem. Somehow we must encourage individuals to save and invest more of their income in order to be financially independent in their later years. Perhaps better education coupled with medical Individual Retirement Accounts should be considered along with pension rules that encourage employer participation.

In conclusion, BellSouth believes that mandatory employer medical insurance without cost control reform will lead to far greater socioeconomic problems; namely, increased unemployment due to increased employer-provided medical costs which would result in higher overall labor costs. The health care access dilemma will not be resolved until this country reduces its health care expenditures. Unless medical delivery costs can be reduced, it would be ill-advised to adopt an expensive social

program for the chronically ill. It is time for us to rationally determine what portion of this nation's resources will be directed to the provision of health care. All social programs are popular with those who benefit. The real questions are how much can we afford and which programs provide the greatest benefit at the lowest cost. BellSouth will be pleased to work with you and your staffs in the formation of public policy regarding health care reform.

Prepared Statement of Lawrence Smedley

Mr. Chairman, members of the Committee, my name is Lawrence Smedley. I am the Executive Director of the National Council of Senior Citizens (NCSC). NCSC represents over 5 million older Americans nationwide through our 5,000 affiliated clubs. The National Council was founded in 1961 to advocate for the passage of Medicare. Alter achieving this goal, the Council turned to other advocacy issues, including National Health Care, Social Security issues, housing and employment programs for the low-income elderly. NCSC also word closely with other organizations to ensure that the policy needs of other age groups are not ignored.

Mr. Chairman, everyone in this room today agrees that the unique American approach to providing health care services is in need of reform. Even the American Medical Association, once the staunchest supporter of the status quo, has developed its own reform proposal, called Health Access America. The system is in disarray. There can be no doubt that the costs being borne by consumers, industry and government are breaking our back.

Since 1980, national spending for health care services has almost tripled—from $240 billion to over $650 billion a year. Of that, consumers are paying one-fourth out of their own pockets.

Health care costs are out of control and we are all feeling the pinch. Yet we stand to lose the battle before a "shot is fired. The costs so astronomical, the problem so large that we risk becoming overwhelmed by the problem—too "numbed" by the numbers to seek a solution. Already the word "crisis," when used to describe the health care system, is a cliche.

Everyone here is familiar with the figures used to show that a crisis exists. Over 50 million Americans are either uninsured or under insured. All too often, when someone with insurance contracts a catastrophic illness, the insurance company will pay for the initial operation, but then cancel the policy. Workers are seeing more and more of their paychecks going to pay for health care. The elderly are seeing their out-of-pocket payments skyrocket. In fact, seniors are paying a higher percentage of their total income for health care than they did before the passage of Medicare. Still, the Administration keeps returning to Congress year after year, asking for greater cuts in this life sustaining program, even after applying the most Draconian cuts the program has ever seen.

American industrial giants in the auto, steel, and communications industry are waking up to the impact of rising health care costs on their bottom line. Yet, for all our awareness of the growing dimension of the problem, our solutions have been so limited in scope they do little more than put "band-aids" over hemorrhaging wounds.

The evidence is unassailable—piecemeal reform does not work. Our health care system is like a balloon, squeeze in one place and it will expand some place else. We pass a hospital prospective reimbursement program and physician costs go through the roof. Congress approved physician payment reform legislation and already the pressure is on to modify it before we can judge how well it will work. Every day, laboratories perform 40 million tests—enough to provide every American with one test every six days. Doctors can "game" the system with the best of them.

Even more disturbing is our high rate of infant mortality. The United States has the highest per capita health care expenditures in the world but we are not getting our moneys worth. In any study, we consistently fall beneath all other industrialized nations. This decay is even more prevalent for non-whites. A black baby born in Detroit has a smaller chance of surviving its first year than a baby born in Costa Rica. Americans should be morally outraged, ashamed, and angry about this, and they are. In Canada, 98 percent of women receive prenatal care. Only 75 percent of American women ever do. This also drives up our medical inflation. Premature and sick babies cost thousands of dollars a day. Yet many of these babies' problems could have been prevented with adequate prenatal care. All while 300,000 hospital beds a day go unfilled.

Other industrialized nations have higher life expectancies and lower infant mortality rates, even as they spend less money on a per-capita basis. Some point out

that when only the over 65 population is examined, Americans have the highest life expectancy. This proves our point. Once someone turns 65 they become beneficiaries of the largest health care program in the nation—Medicare. Regardless of any other concerns, if you are fortunate enough to live to be 65, your health care needs will be met. But Medicare provides very few preventive care benefits and older citizens tend to be sicker than their younger counterparts which could be one reason that Americans spend about $2,400 a year for health care, while Europeans spend only about $1,200.

Other countries are able to contain health care costs and are not suffering the 15 to 20 percent medical inflation a year like the United States. Also, in the United States 23 percent of our health costs go to administration, in Canada, 13 percent. American hospital administrators are increasing at a rate four times faster than physicians. Mr. Chairman, if all we did was to lower our administrative costs to 13 percent, we would save, as a nation, about $50 billion a year—enough money to provide health insurance for every American currently without it.

The National Council of Senior Citizens and its members are convinced that fundamental, systemic reform of the way we provide health care in the United States is essential and that we must begin the process now. We must burst the health care balloon and put in its place a more equitable, more efficient and more affordable national health care program. As you have no doubt heard many times, the United States alone with South Africa, is the only nation that has not adopted some form of national health program. Yet, such a program can ensure that all Americans have access to quality, affordable health care. What are we waiting for?

Developing a national program even makes sense economically. If we had adopted strong cost-containment measures, as did our Canadian neighbors, in the 1970's and kept our health expenditures at 8 percent of G.N.P we would currently have an additional 4 percent of G.N.P at our disposal to do with as we wished. This wealth could have been used to increase health benefits to all our citizens, provide greater funding for education, infrastructure improvements, or deficit reduction.

Polls show that 67 percent of Americans favor the Canadian model for a National Health Care System. This model, while not perfect, is extremely popular among Canadian citizens—only three percent said they would return to a U.S.-style system; 89 percent of Americans say our health care system needs fundamental change or complete rebuilding.

Many critics of a proposed American national health care system raise the specter of "rationing". Yet, we in the U.S ration care as much, if not more so, than they do in Canada. Theirs is a rationing system based on need, ours is one based on wealth. Even for those lucky enough to be covered by one of the nation's 1,500 health insurance programs, health care is rationed—with large, profit-minded companies deciding what care is to be provided and what care people can do without. Even if coverage is provided, many companies still require patients to pay a great deal of costs out of their own pockets.

In Canada, everyone is given health care regardless of his or her ability to pay. Costs are kept down by the national government controlling how much doctors can charge and hospitals can spend. Standards are kept high by the Federal Ministry of Health and local governments which oversee day-to-day operations. Plus, patients are still free to choose their physicians, and doctors are privately employed. And Canadian physicians are still well-paid, earning five times what an industrial worker makes.

One argument often levelled against the Canadian system is that it limits access to exotic medicine and non-emergency surgery. Let's face it: high-tech medicine is expensive. Yet, in the United States, hospitals and clinics routinely buy CT scanners, MRIs and other extremely expensive equipment. Such equipment is either under utilized or used unnecessarily (i.e., using an MRI scan for a broken bone). These unnecessary costs then continue to fuel the fires of medical inflation.

The Swedes have solved the exotic technology problem without undue hardship by establishing six high-tech regional centers (one center for about every million and a quarter people). Problems that cannot be handled at a local level are referred to these centers. Indeed, this is how some planing problems are handled in the U.S. with some facilities concentrating on burn victims, others on heart attacks, cancer, or stroke for example. Clearly, we should examine all of our options before choosing what is right for us. But I do not, and cannot, believe that we cannot solve this problem.

Mr. Chairman, you and other members of the Committee may have wondered why the National Council and its members are so passionately committed to seeing the creation of a national health care system when elderly Americans already, in

essence, have one. The answer is quite simple. From our experience with Medicare we have learned a very painful lesson: piecemeal reform does not work.

Older Americans would also like to see the creation of a long-term care program and we feel this can only take place under the umbrella of a national health plan.

NCSC wants universal health care for our grandmothers and grandfathers who may need to enter a nursing home. We want it for our fathers and mothers struggling through a devastating illness. We want it for our disabled brothers and sisters who need long-term care in the home. We want it for our sons and daughters so they will not have to worry about the high cost of health insurance as they move away from home for the first time. And most of all, Mr. Chairman, we want it for our grandsons and granddaughters. We want them born healthy so they can live the lives their parents and grandparents envision for them.

Mr. Chairman, the inevitable force of change is coming. Congress and Congressional Commissions have been studying this issue for years now. Hearings have been held here in Washington and across this great country. Thousands of our members have attended these hearings in order to lead the fight for national health care. Just as the campaign for Medicare began after a long period of neglect for the health of our people, the time for America to enact a universal, comprehensive national health care program may be in sight. At NCSC's 20th Constitutional Convention last July our membership adopted the following nine-point program in order to establish a basic set of principles for developing national health care legislation. We offer these principles to the Committee and to Congress. We urge you to consider them carefully as you move forward in the creation of legislation.

UNIVERSAL ACCESS

Under the program, every American will be covered, regardless of ability to pay. Basic health protection must be considered a right and the program must clearly establish this principle.

COMPREHENSIVE BENEFITS

In addition to protection for hospitalization and physician services, the program must cover all medically necessary health and preventive services, long-term institutional and home health care, and other essential health services.

FINANCING

Any system of financing a new national health care program must be broad-based and progressive, based upon our nation's traditional approach to financing social insurance programs.

COST-SHARING

Cost-sharing requirements on beneficiaries must not create economic barriers to receiving adequate health care. Deductibles and co-payments penalize the sick and therefore should not be relied upon as sources of financial support for the program. All physicians would be required to accept assignment and would not be allowed to pass along additional fees to beneficiaries.

Quality Assurance

Standards would be established to govern patient care in all medical settings. Independent oversight of the medical profession and peer-review organizations would monitor the quality of all medical care. Physicians, nurses and other health care professionals who have demonstrated a commitment to providing the highest quality care should be recognized and rewarded.

COST-CONTAINMENT

A system of budgeting for all health care services would be established and adhered to in determining payment policies to service providers. Prospective hospital budgeting and a national physicians' fee schedule coupled with expenditure targets and negotiated on an annual basis will act to control health care costs.

HEALTH PLANNING

Resources for capital expenditures on new construction and rehabilitation of existing facilities would be allocated on the basis of local, State and regional needs for additional health care services. This will ensure that the health care needs of all our citizens will be considered in determining spending patterns for the new technologies and services.

PATIENTS' RIGHTS

Patients must be treated in a timely manner and with compassion and decency and a patient-grievance procedure must be established. The burden of seeking reimbursement for services rendered should fall on the health provider and not the patient.

PROGRAM ADMINISTRATION

The national health program will be administered in such a way as to assure a strong role for the Federal Government and the States. In addition, health care consumers must have the right to participate in the administrative and policy-making decisions at all levels of government.

National health care is needed now. The time is right. A large majority of Americans support such a program. Polls show that a majority of physicians actually support national health care and corporate America is demonstrating increasing support. This country should not allow another child to die because the parents do not have the money to buy insurance, another pregnant women should not be turned away from an emergency room because that hospital does not accept Medicaid patients. Another senior citizen must not be forced to impoverish herself or himself because of a need for constant care. And most of all, Mr. Chairman, sick people should not have to wait until they are forced into an emergency room to receive the care they need. Preventive care saves lives and money. As you have all seen back in your home States, the political will exists outside of Washington to establish a national health care program. How long do we have to wait for it?

The CHAIRMAN. The committee stands in recess.

[Whereupon, at 11:35 a.m., the committee was adjourned.]

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